FOSTER AND KINSHIP CAREGIVER PERCEPTIONS OF SUPPORT AND TRAINING IN CANTERBURY, NEW ZEALAND.

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ABSTRACT

This dissertation describes a study that investigated the perceptions of foster/whänau caregivers of support and training provisions in Canterbury, New Zealand. The study used both qualitative and quantitative methods. The qualitative component consisted of six questions presented to caregivers at individual or couple interviews. Major themes identified in the response to these questions indicated that participants are generally feeling under-supported and disrespected by social services staff, overwhelmed by the range, severity and difficulty of their children's behaviours, isolated in their role, unable to access relief care and a lack of provision and support for training in local areas. Participants also indicated a desire for training on the etiology and management of difficult child behaviours, managing birth family contact and legal issues relating to allegations and permanency. Areas of current support that caregivers indicated are useful included the support provided by Caregiver Liaison Social Workers, school and early childhood education staff, general practitioners, and other caregivers

The quantitative component consisted of a survey covering basic demographic information. A modified child behavioural checklist, containing selected items from the 'Child Behaviour Checklist' and the 'Assessment Checklist for Children' was constructed to assess the range of problematic child behaviours caregivers are experiencing and how prepared they felt in dealing with them. Findings indicated that the participants are experiencing a range of severe behaviours well outside the normal experience of parents but are consistent with those reported in the international literature for children in care. The PSI was used to assess caregiver's stress levels relating to their parenting role. Participants reported high levels of stress particularly in the child domain of the PSI with sub-scales in the high to clinical range across this domain. Implications of theses results are discussed including implications for the caregivers, social welfare practices and the development of future training packages for caregivers.

Key words: Foster Caregivers, Kinship Caregivers, Whänau Caregivers, Permanency, Respite, Temporary Care.

CHAPTER 1

INTRODUCTION

The number of children being placed in 'out-of home-care' in New Zealand is rising. The Department of Child Youth and Families Annual Report for 2006 stated that 5,314 children were in care on June 30th (for examples see CYFs, 2006). This is an increase of 16% over the figures reported for the previous year. Notifications had increased over the same time frame by 24.7% to a figure of 66,210. This is a significant increase on the figures reported for children in care in June 1999 (3,533) and the number of notifications received in that year (19,521). In New Zealand, similar to other countries in the Western World, the majority of these children are either placed with whänau/family members (referred to in literature as kinship care) or in foster placements (CYFs, 2006, p. 9). Children placed in 'out-of-home' or 'alternate' care generally come from backgrounds that put them at high risk of developing a range of behavioural, educational and mental health difficulties. The severity, frequency and complexity of the problems reported in children in care are much higher than those in the general population and more closely reflect those found in clinically referred populations (Armsden, Pecora, Payne, & Szatkiewicz, 2000; Keatinge, Tarren-Sweeney, Vimpani, Hazell, & Callan, 2000; Rutter, 2000; Tarren-Sweeney & Hazell, 2006). This means that foster/whänau caregivers are encountering a range of emotional, behavioural and educational difficulties from the children in their care that are far outside normal parenting experiences. The expectation is that the provision of a nurturing home environment with these alternative caregivers will go a long way to alleviating complex and severe difficulties stemming from the children's original adverse family environments (Nutt, 2006; Schofield & Beek, 2005; Tarren-Sweeney & Hazell, 2006).

> *"For foster children from high-risk birth family backgrounds of adversity and maltreatment, the hope is that parenting provided by foster carers will reverse*

developmental damage and enable them to achieve good outcomes in adult life." (Schofield & Beek, 2005, p. 3)

The needs of these children are extensive and complex and are poorly conceptualised within both research and clinical practice (Rutter, 2000; Tarren-Sweeney, In Press; Tarren-Sweeney & Hazell, 2006). Yet the expectation invariably exists that foster parents will succeed in providing these children with care and support that will 'cure all'. The assumption being that 'love' will, at the end of the day 'conquer all'.

An important question then, is how can individuals and couples from diverse backgrounds, abilities and experience be expected to provide this type of 'super-parenting'? What support and training is being provided to equip and assist them with this? How satisfied are they with the support and training they are receiving? Do they feel that they are being adequately equipped for dealing with their charges on a day to day basis? In searching the literature for answers to these questions it became apparent that there is scant evidence on caregiver's perceptions of their support and training needs. There was no information available in the local context, and research that looked at these questions at an international level was also limited (Hudson & Levasseur, 2002; Nutt, 2006; Tarren-Sweeney & Hazell, 2006). While the epidemiology and behaviour of children in care has been the focus of a number of studies (Armsden, Pecora, Payne, & Szatkiewicz, 2000; Keatinge, Tarren-Sweeney, Vimpani, Hazell, & Callan, 2000; McKenzie, 1994; Randazzo, Landsverk, & Ganger, 2003; Rutter, 2000; Schofield & Beek, 2005; Tarren-Sweeney, 2006, , In Press; Tarren-Sweeney & Hazell, 2006; Tarren-Sweeney, Keatinge, & Hazell, In Preparation) caregiver perceptions of their support and training as they deal with these behaviours has received very little attention (Brown & Bednar, 2006; Gordon, McKinley, Satterfield, & Curtis, 2003; Hudson & Levasseur, 2002; Nixon, 1997; Nutt, 2006; Orme, Cherry, & Rhodes, 2006).

The author thus undertook a small exploratory study of the support and training that caregivers currently receive, as well as their perceptions of this, and what further support or training they believe would be of benefit to them in their role. They are, after all, the end users of these services and therefore have important information to share regarding what they need as they provide day to day care for their children. It is hoped that this information may be useful in the design of future training packages for caregivers, for informing policy and practice within the social services sector, and as a precursor to a more extensive study of the training and support needs of New Zealand caregivers.

Some important considerations when exploring support and training provided to foster carers include, the kind of behaviours and issues they are likely to experience on a day to day basis from the children they care for; the legal and governmental systems they are working within; the historical context and perceptions of foster care within New Zealand; and the training and support currently available to caregivers.

The following section will provide an overview of the New Zealand Social Services system to enable the reader to compare the reviewed literature with the current context. The next chapter will review the literature for each of the above considerations, starting with the research that has explored the epidemiology of children in care. What does the research indicate about the day to day behaviours caregivers are likely to experience? The research covering caregivers support and training perceptions will then be reviewed. Consideration will be given to how the perceived needs reported by caregivers relate to the actual behaviours reported in children in care. Given the scarcity of information in the local and international literature the reviews of the literature is somewhat scant. The term ‘fostering’ is used generically to apply to both foster and whänau placements.

The Provision of Out-of-Home Care in New Zealand

It is not the purpose of this section to offer a comprehensive overview of New Zealand family law or a complete history of foster care in New Zealand but to touch on a few of the systemic and contextual issues which currently impact on foster and whänau caregivers. This basic understanding is necessary to make sense of the information gathered through the interviews with the participants.

New Zealand Legislative and System Overview

The two main legal Acts that guide social welfare policy and practice in New Zealand are the Children, Young Persons and Their Families Act (1989) (CYFs Act) and the Care of Children Act (2004). Both The CYFs Act and the Care of Children Act have what they define as a paramouncy principal. This principal is supposed to provide the overarching guideline for the interpretation of the Acts into practice. The principal for both Acts is that decisions are to be based on the 'best interests of the child' (Pawson, 2002) .

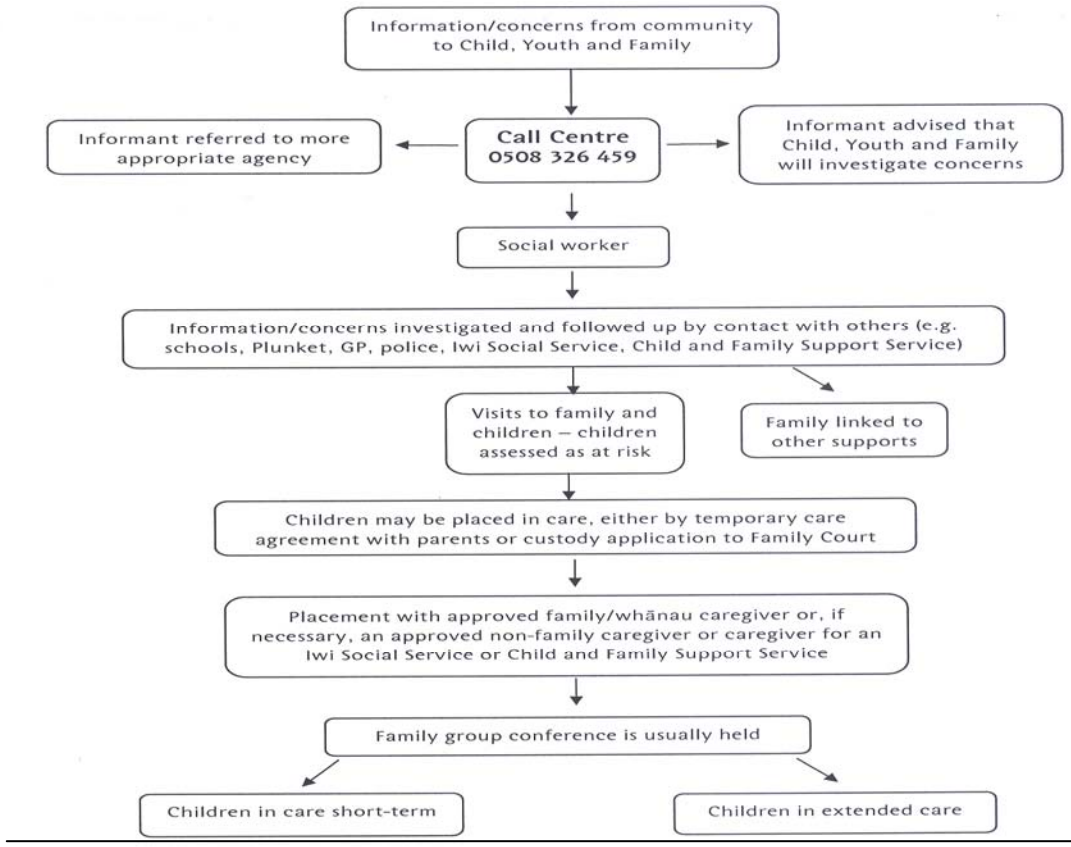
Children in the New Zealand context come into care because there is considered under the CYFs Act to be sufficient evidence that they are at risk in their family setting and are in need of state care and protection. An overview of the process by which children come into care can be seen in Figure 1 below.

Children who are placed in out of home care in New Zealand are placed in either emergency, respite, short-term, extended or permanent care arrangements. Emergency care refers to situations where children are removed from their families in a crisis situation. Respite care refers to regular short term placements designed to give parents or caregivers a break (e.g. one weekend a month). Short term care orders are put in place while a decision is being made about the long term placement of children. They are usually 28 to 56 days in length and are often used to provide parents with the opportunity to meet requirements for the return of their children.

Extended care arrangements are made when children are expected to be in care for a longer period but permanency decisions have yet to be finalised. Again they provide an opportunity for parents to meet requirements outlined by the Family Court or the Whänau Group Conference for the return of children. CYFs policy states that reviews of extended care arrangements (with the view of moving towards permanency) are to happen every six months for under 7year olds and annually for 7 – 16 year olds. Extended care situations are reviewed by the Family Court or Family/Whänau Group Conferences. Permanency refers to situations where caregivers have taken Parenting Orders under the Care of Children Act 2004 and the children are considered to reside with the family on a 'permanent' basis. Once a child is placed in a permanent situation they are no longer considered under the care of CYFs, although service and support orders can be kept in place for a temporary duration to aid the transition.

Figure 1.

How Children Come Into Care (Taken from CYFs, 2003a, p.19)



Each child that is taken into CYFs care is generally allocated a case manager social worker. (The Department of Child Youth and Families Annual Report for 2006 notes that at June 2006 there were 1,092 unallocated cases.) According to CYFs Practice Guidelines the child's social worker has the responsibility of placing the child, providing care plans, visiting the child on a 'regular' basis, supporting the child's parents to meet requirements, arranging contact visits, supporting caregivers to meet the child's needs, providing caregivers with up to date information regarding the placement, making referrals as required, assisting caregivers with financial resource information, including the caregiver and whänau in consultation procedures, regularly assessing the child's needs and the placing and helping children with transitions in care or on return home. (CYFs, 2003b)

Each caregiver within the New Zealand Social Welfare is also allocated a Caregiver Liaison Social Worker. Caregiver Liaison Social Workers have the responsibility to support caregivers with the children in care, recruit caregivers, provide initial and ongoing training for caregivers, represent caregiver wellbeing at meetings, review and visit each caregiver twice a year, liaise with social workers about the placement of children. There are a number of other roles within the CYFs Department structure that impact on the day to day lives of caregivers. These include Practice Managers, Social Worker Supervisors, Care and Protection Coordinators, Youth Justice Social Workers, and Resource Workers. Practice Managers and Social Worker Supervisors provide part of the chain of command that caregivers can access when they are not receiving support that they consider adequate from their Liaison or Case Social Workers. Care and Protection Social Workers have the responsibility of organizing and running Whänau/Family Group Conferences and recording and following up on decisions made at these conferences. Youth Justice Social Workers have a similar role to Care and Protection Coordinators with the youth who have come into care through the courts. In addition to convening and managing Whänau/Family Group Conferences for this client group they have the role of liaising with the

New Zealand Police around placement decisions. One role of Resource Worker is to help caregivers manage contact with biological parents where this is deemed necessary. They are most likely to be involved where the court has ordered that contact be supervised (CYFs, 2003b).

The New Zealand Social welfare system provides care and protection for children aged form birth to 17years. The distribution of ethnicity among New Zealand children in care and the New Zealand population in general is listed in Table 1 indicates that Maori children are notably over-represented among children in care. The numbers of Maori children in care in New Zealand has implications for the training of both whänau and foster caregivers. It also impacts on the day to day practices of caregivers as the attempt to integrate children into their families that come from cultural practices that may be quite different from their own (CYFs, 2006).

Table 1.

2006 Ethnicity Percentages† for the New Zealand Under 17 Population and Child, Youth and Family Services Client base. (Taken from CYFs, 2006, p. 25)

Service	NZ Pakeha	NZ Maori	Pacific Nations	Other Ethnicity
Intake	37.4%	45.3%	12.3%	4.9%
Care and Protection Services	42.1%	46.3%	8.0%	3.6%
Youth Justice Services	34.7%	52.3%	8.9%	4.0%
Adoption Services	20.3%	13.2%	20.1%	29.0%
NZ under 17 population	58.0%	24.0%	10.0%	8.0%

† Note that some people record more than one ethnicity accounting for a total greater than 100%.

Historical and Contemporary Shifts in Policy and Practice in Foster Care in New Zealand

New Zealand shares a number of common historical factors in foster caring with other Western cultures. These include the origins of care and shifts away from institutional care to family based care. Formalised family care in New Zealand originated with religious organisations such as the Catholic Social Services. It was primarily focused on short term and respite care for parents who were struggling. Children who required longer term care were generally placed in institutional care facilities such as orphanages. Formalised foster care is a relatively recent

phenomenon as up until the late 80s and early 90s a range of children who were considered 'unfosterable' were still residing in residential care. While a small number of children still reside in institutionalised care, there has been a major shift in practice to the placement of children in family foster care or group homes. This was based on the understandings derived from attachment theory and the notion that every child needs a family and a primary attachment figure to develop (Bowlby, 1988). This basic underlying philosophy is evident in a range of literature that guides current policy and practice within CYFs (CYFs, 2003a, , 2003b).

> *"Children and young people have a right to stability and care in a nurturing and loving family/whänau of their own. To grow and develop in a healthy way, all children need affectionate relationships in which they are loved and can love in return. They need security and a sense of belonging. They need opportunities to learn and experiment and become independent and responsible. For children to value themselves as people they must know that not only do they have an adult important and vital to them, but that they are important and vital to that adult."* (CYFs, 2003a)

The move from institutionalised care to family based care has had a huge impact on caregivers. The children that were previously considered to be 'unfosterable' were generally those with the most severe behaviour problems and therefore the most difficult to care for. This has led to the aforementioned situation where the population of children in care with foster parents now more closely reflects a clinical population with a high range of mental, educational, health and behavioural problems.

An informal system for children being raised by extended family has existed alongside the formalised placement of children in care in New Zealand as with many other countries in the Western world. This system is pertinent to the understanding of current social work practice in the New Zealand context as it is particularly important in the Maori cultural context. The concept

of whānautanga underpins a number of the processes and policies adopted into current social work practice and New Zealand family law. This can be seen, for example, in the procedures outlined by which children are taken into the care of the state. In these procedures a whānau or family group conference is called as the first level of decision making for the long term placement of children into care. The purpose of the whānau conference is for the family to reach an agreement amongst themselves, and with the department, about the care and safety of the children. Department statistics report that agreement is reached in 86% of whānau/family Group Conferences (CYFs, 2006). This process acknowledges the pre-eminent place of the whānau in the children's life and the right of the extended family unit to be involved in all levels of decision making. The emphasis on whānau is also extremely evident in the weight placed on returning children to their parents or failing that in placing them with extended family members. This is evident in both policy and New Zealand family law.

> *"Planning for permanency proceeds in the following sequence and is directed towards the child:*
>
> • *returning home*
>
> • *being placed with extended family or whānau on a permanent basis (with custody and/or guardianship orders) or, where not possible,*
>
> • *being placed with a new family on a permanent basis (either the existing non-family caregivers or new non-family caregivers take custody and/or guardianship orders)*
>
> • *being supported to independence in the case of a young person."* (CYFs, 2003a, p. 1.13)

> *"Subject to section 6 of this Act, any Court which, or person who, exercises any power conferred by or under this Act shall be guided by the following principles:*

> *a) The principle that, wherever possible, a child's or young person's family, whänau , hapu, iwi, and family group should participate in the making of decisions affecting that child or young person, and accordingly that, wherever possible, regard should be had to the views of that family, whänau , hapu, iwi, and family group:*
>
> *b) The principle that, wherever possible, the relationship between a child or young person and his or her family, whänau , hapu, iwi, and family group should be maintained and strengthened."* ("Children, Young Persons, and Their Families Act", 1989)

The impact of this on foster caregivers is that children are often placed with them and then removed again. This can at times mean that caregivers, in the interest of self preservation, will hold back on establishing strong emotional ties with the children placed in their care. This in turn impacts on the children's sense of safety and trust. It also makes long term planning for caregivers a difficult task, as they live with the sometimes day to day, uncertainty of not knowing how long a child is in their care.

Further implications from this arise from ongoing contact with birth families. As resources become more and more scarce within social services departments the current trend is an expectation that caregivers will often take a larger role in the execution of contact visits with parents. This poses a range of conflicting issues for caregivers. While most would probably indicate an understanding of the importance for children in keeping up contact with birth parents, the process of dealing with contact visits is often fraught. Relationships with birth parents can often be difficult and in the case of whänau caregivers there is an extra element of tension. Caregivers are also left to deal with the range of difficult behaviours that children can display after contact visits that are part of the normal adjustment process for these children.

CHAPTER 2

LITERATURE REVIEW

Children in Care

As mentioned, children in out of home care are placed at high risk of developing a range of educational, behavioural and mental health problems. Studies on the prevalence of mental health disturbances in foster children in America, Europe and Australia report findings of prevalence rates that are significantly higher than those reported for same age children in normative samples (Armsden, Pecora, Payne, & Szatkiewicz, 2000; Rutter, 2000; Tarren-Sweeney & Hazell, 2006).

> *"First, there is consistent evidence that the rate of emotional, social, behavioral and educational problems found in children in such care is substantially higher than that in the general population."* (Rutter, 2000, p. 685)

The subject of this paper is the impact of this on the support and training needs perceived by caregivers rather than the mechanisms as to why children in care manifest a higher prevalence of problems with education, mental health and social functioning. It suffices to say that a complex range of genetic, pre & peri-natal experiences and environmental influences, both prior to and on entry into care, combine in a reciprocal manner to place children in care at increased risk for developing a range of problems across their lifespan. It should also be noted that not all children who enter care evidence problems in some, or all, of these areas. The mechanisms of risk and resilience displayed by children in care are still the subject of extensive research and much has yet to be understood in this area (for examples see Rutter, 2000; Tarren-Sweeney, Submitted).

New Zealand, as a Western culture, shares a number of common features with other Western cultures, making the findings of the international research studies of interest. Given that

New Zealand also has a range of unique cultural characteristics care should taken in assuming that prevalence rates in New Zealand children in care are the same as those indicated in international research. However, there is, at present, no similar information available in the New Zealand context and New Zealand children entering into court-ordered, out of home care, are likely to have experienced a similar range of adverse family conditions to those entering care in Australia, America and Europe. It is therefore likely that they will experience a similar range of behavioural, educational and mental health impairments resulting from their early adverse experiences.

A study completed in New South Wales, Australia is of particular interest (Tarren-Sweeney & Hazell, 2006). As our nearest geographical neighbour, Australia can be argued to share more in common contextually with New Zealand than America or other European countries. One similarity of interest between the New South Wales study and the New Zealand context is the high use of kinship/whänau care placements common to both. This study is also of particular interest as it focuses on a range of behaviours that are evidenced in children in care that had not previously been adequately identified. These problems include self harm behaviours, food and eating problems, attachment difficulties, peer problems, trauma responses and sexualised behaviour. The study used both the Child Behaviour Checklist (CBCL) and the Assessment Checklist for Children (ACC) to gather baseline information from caregivers on the mental health of 347 children in court ordered care in New South Wales. The children included in this study were ranged in age from four to ten years. By using the CBCL, comparisons can be made with international data regarding the prevalence of commonly observed behavioural and mental health problems in children in care and with normative groups (Achenbach & Rescorla, 2000; Achenbach & Rescorla, 2001; Armsden, Pecora, Payne, & Szatkiewicz, 2000). The ACC is a caregiver report measure that was designed specifically for this study to assess the problems

mentioned above that are not adequately covered by the CBCL but are observed in children in care.

Findings indicated that these children showed significantly higher levels of mental health problems than children in normative samples and that the profiles of children in care closely reflect that of a clinical population. Areas identified that had particularly high prevalence rates included thought problems, concentration problems, peer and adult social interaction problems, conduct problems and aggressive behaviour problems. A range of other difficulties were identified that are rare in the general population and that are considered indicators of severe disturbance. These included developmentally inappropriate sexualised behaviour, non-reciprocal and indiscriminate interpersonal relationship, self-injury, abnormal pain response, suicidal talk and eating and food maintenance problems. It was also interesting to note that, in this study, there were several areas of mental health difficulties that were significantly less prevalent in children in care than in the general population. These problem areas included shyness, perfectionism and self-conscious behaviour (Tarren-Sweeney & Hazell, 2006).

While Tarren-Sweeny & Hazell (2006) note that their general prevalence data may be high due to sampling bias, findings of this study show patterns of mental health and social competency problems that are consistent with findings from studies in America and Europe (Armsden, Pecora, Payne, & Szatkiewicz, 2000; Rutter, 2000). Armsden, Pecora, Payne, & Szatkiewicz, (2000), for example, in their summary of previous research, cite CBCL scores indicating a prevalence of clinically significant behaviour problems at rates between two to four times greater among children in foster care, than in normative samples. There is evidence to suggest that this figure may be a little lower for children in kinship care, though prevalence rates are generally still elevated in comparison to normative samples in this group as well (Armsden, Pecora, Payne, & Szatkiewicz, 2000; Tarren-Sweeney & Hazell, 2006). International data also

suggests that children in care are experiencing elevated rates of difficulties with academic and social competence in the school setting (Armsden, Pecora, Payne, & Szatkiewicz, 2000).

What this means in the day to day reality of caregiver's lives is that they are caring for a number of children with high levels of difficult behaviours that can be wearying and taxing on caregiver resources. A number of the difficulties reported among children in care can also impact on the caregiver's ability to establish affectionate connections with the children. The children's aggressive, detached, avoidant, defiant or indiscriminate behaviours all potentially impact on the caregiver's ability to establish unconditional bonds, and the children's ability to establish meaningful relationships, making them difficult to care for (Nutt, 2006; Tarren-Sweeney & Hazell, 2006) .

Another impact of the high prevalence of educational, behavioural and mental health problems among children in care is that caregivers must learn to navigate the special education, health and social welfare governmental departments in order to access extra support. This in itself is often a task fraught with frustration and added stressors. Services are limited and waiting lists are long. Interventions are often split between numerous organizations and fragmented, with the advice that caregivers receive, at times contradictory and inconsistent. All of these factors associated with the mental health, behavioural and educational problems evidenced among children in care are of themselves time consuming and draining on caregiver resources (Tarren-Sweeney & Hazell, 2006). This evidence provides support for a range of the perceived needs reported by caregivers in the studies in the previous section. The range of difficult behaviours evidenced by children in care can be assumed to result in an actual need for caregivers to receive a range of support services and training. This training and support needs to be focused around the day to day management of theses behaviours and issues and presented in a manner that is contextually relevant to the reality of parenting foster children.

Caregiver Research

While the bulk of research has tended to focus on the needs of children in care there is a recent focus on the needs of the caregivers themselves (Brown & Bednar, 2006; Gordon, McKinley, Satterfield, & Curtis, 2003; Hudson & Levasseur, 2002; Nixon, 1997; Nutt, 2006; Orme, Cherry, & Rhodes, 2006). As yet there is no research in the New Zealand setting, but a number of common themes are evident in the research from international settings. Generally caregivers report a lack of support and services; difficulties with communication with social welfare agencies; a sense of not being respected by social services staff; and difficulties managing birth family contact. These experiences are felt amidst a sense of crisis within social welfare agencies (Brown & Bednar, 2006; Gordon, McKinley, Satterfield, & Curtis, 2003; Hudson & Levasseur, 2002; Nixon, 1997; Nutt, 2006; Orme, Cherry, & Rhodes, 2006). Findings from the five key studies are reported below.

Gordon, McKinley, Satterfield, & Curtis (2003), examined kinship caregivers' perceptions of support services provided in the United States. Several themes were identified in four focus groups conducted with 37 kinship carers. Caregivers identified a need for increased respite care, and training. They found the social services systems stressful to navigate, high caseworker turnover frustrating and the lack of respect reported from social services staff an added stress that generated mistrust. These carers voiced a degree of social isolation and difficulty in maintaining social support networks. They also expressed a loss of freedom and flexibility, which they perceived as being due to the need for establishing firm routines for the children and in having to attend a wide range of meetings and appointments. Family networks were also often reported to be strained, adding an extra element of stress unique to kinship carers. Kinship carers also noted that they had to make significant adjustments to their lifestyles and future life plans that required a high level of sacrifice. Caregivers in this group also indicated that they felt undervalued by social welfare staff and reported a feeling of powerlessness as they were

excluded from the decision making process. This presented problems in their day to day care of their children as they did not "Know what to expect today to plan for tomorrow" (Gordon, McKinley, Satterfield, & Curtis, 2003, p. 88). Caregivers in this study also reported a lack of understanding of the legal issues such as permanency and their legal rights and responsibilities as caregivers (Gordon, McKinley, Satterfield, & Curtis, 2003).

While kinship carers are a unique group within the foster care context a number of themes identified in this study have also been reported in studies that include foster parents. Hudson & Levasseur (2002), for example undertook a study of Canadian foster caregivers using a questionnaire sent to all caregivers in the sample area. 66 caregivers returned the questionnaire; a response rate of 41%) These caregivers also reported a perceived lack of respect and recognition from social welfare staff. Again a sense of powerlessness in regards to the decision making process seems to be a strong theme evidenced by comments quoted among the sample caregivers.

> *"Foster parenting is a big commitment and we need to know we have input and some say that the plans will respect our family lifestyle."* (Hudson & Levasseur, 2002, p. 861)

They went on to note five main types of support that were identified as necessary for carers. These included "…compensation, tangible support, emotional support, relief and recognition" (Hudson & Levasseur, 2002, p. 857). In the area of emotional support, a key finding was that foster carers perceived a need to be able to access a non-judgmental ear on which to unload in times of stress. One caregiver is quoted as noting that:

> *"Support means when stress levels are high, being able to call someone and share areas of concern without being seen as not being able to cope."* (Hudson & Levasseur, 2002, p. 860)

Compensation was also identified as another area in which caregivers felt they were not adequately supported. The main tangible support that caregivers in this study identified was the

need for respite care. This was a contentious issue for some carers however, who felt that respite singled out foster children as being different from their own children with a detrimental impact on their sense of self. Others are reported as seeing it as essential for the caregivers to deal patiently with the children and to maintain their own birth children's sense of family (Hudson & Levasseur, 2002).

Training was also identified by carers, in this study, as a tangible area of support that was valued. It was also recognized as having an element of emotional support in that it provided caregivers with the opportunity to network with others in the same situation. The main area of interest for training identified by carers in this sample was around the difficult behaviours of the children they were caring for (Hudson & Levasseur, 2002). Another major area of support and difficulty identified by foster parents in the study by Hudson & Levasseur (2002) is the area of ongoing contact with birth families and the impact of this on integrating foster children into the foster family.

The difficulty of tension between the agency expectation that foster children will be included as one of the foster family, alongside the expectation that they will also continue to be a part of their birth family, is also a major theme in the research undertaken with foster carers in the U.K. by Nutt (2006). Information on the methodology used in this study is scant. The author does make a passing reference to "in-depth interviews" with 46 foster carers from diverse backgrounds and care experiences ranging from "quasi adoption to emergency placements." (Nutt, 2006, p. 1) One of the major findings noted by Nutt (2006) is that the day to day reality of parenting for caregivers is constrained by public policies, resulting in caregivers feeling disempowered and undervalued in their roles. Recent developments in fostering policy that places emphasis on the return of children to their birth parents further compounds this and is also noted to impact on caregivers' bonding with the children in their care. It is reported that caregivers will hold back from developing emotional bonds with the children in their care to contain the sense of grief and

loss that caregivers experience when children return home. Another tension noted by Nutt (2006) between the private and public lives of caregivers is that policy often delineates for caregivers how and in what way they are to behave as parents, again with the impact of disempowering caregivers. These prescriptions impact on the ways that caregivers can comfort, display affection, set boundaries, go on outings and a range of other day to day activities. Caregivers have been able to engage without thought with their own children and often seem to find policies and restraints placed on them by social welfare and family law difficult to balance. Caregivers are reported to express confusion as to how to meet the children's needs for warm and responsive parenting and a degree of normal family life, as well as stay within the constraints of policies and procedures outlined by social welfare services (Nutt, 2006).

In a related research paper the main causes of foster parent stress was explored. (Jones & Morrissette, 1999) This research surveyed 96 Canadian caregiver's experience of stress. The caregivers were asked to identify the frequency and degree of a list of stressors that had previously been generated by a number of caregivers. The research identified 11 main themes resulting from this survey (refer to Table 2.). These themes closely parallel the areas identified previously as areas where support and training were of particular importance to caregivers. It stands to reason that the areas that caregivers find most stressful are the ones in which they perceive the greatest need of support (Jones & Morrissette, 1999).

Table 2.

Foster Parent Stress Themes Identified In Canada. (Jones & Morrissette, 1999)

1. The relationship of the foster parent with the child
2. The relationship of the child with their birth family
3. The relationship of the caregiver with the birth family
4. The caregiver's relationship with social welfare staff
5. Foster child behaviour
6. Foster child educational achievement
7. Mental health status of the foster child
8. Foster parent well-being (including the need for respite care, preservation of the caregivers own family and isolation from the community)
9. Issues with social welfare policy and practice (including staff turnover, policy changes, the removal of children without consultation, inconsistencies in social worker practice, legal issues, and reimbursement of expenses)
10. Communication issues (including lack of responsiveness from social welfare staff)
11. A lack of information around planning, permanency and contact visitation.

While training was identified as an area of support that was considered important by caregivers very few studies have been undertaken that look at the delivery and effectiveness of training for foster parents (Pacifici, Delany, White, Cummings, & Nelson, 2005; Pacifici, Delany, White, Nelson, & Cummings, 2006). In particular, the study undertaken by Pacifici, Delany, White, Nelson, & Cummings, 2006 explored the effectiveness of two web based training courses offered online by the Foster Parent College. The Foster Parent College is a website (fosterparentcollege.com) that has been developed by North West Media, an American company that publishes and markets books, and materials as well as interactive multimedia curriculums based on social learning and attachment theory. The participants included 97 foster parents from the California area who enrolled for the courses voluntarily. The two courses evaluated in this study covered 'Lying' and 'Sexualised Behaviour' in foster children. The courses are reported to provide theoretical information on the etiology of behaviours and practical tips for parenting specifically related to children in care. The importance of embedding the knowledge in the context that carers experience is evident throughout this paper.

> *"Conventional parenting approaches that deal with typical problem behaviours are simply not effective with these children. Furthermore, parents need to understand these problems in contexts that accurately reflect their family configuration and experiences."* (Pacifici, Delany, White, Nelson, & Cummings, 2006, p. 1331)

The courses were presented via the internet using multimedia technology, specifically video formats and a discussion board. Effectiveness was defined by an increase in the participants' knowledge base in the relevant problem areas, self reported increased feelings of efficacy in dealing with the problem areas and a customer satisfaction survey. Findings showed that after two weeks, participants in both subject areas displayed an increase in knowledge of the etiology of the problem areas and methods for parenting children with these issues. Customer satisfaction was reportedly high for both courses. The results also showed that in regards to lying behaviour, foster parents reported a significant level of increase in feeling able to deal with the problems in their children. The results in the measure for the sexualised behaviour course did not meet significance criteria but did show an increase in ratings of efficacy from participants.

While this research does highlight the effectiveness of using the internet as a medium for training foster carers, it does not provide any comparative effectiveness information with other training formats. Additionally, it does not provide any information on caregiver's preferences for web-based training over other methods of training. Two other areas that are not covered by the design used in this research include: the extent to which information is retained over the longer term; or if the information was transferred from theoretical learning into actual differences in parenting practices. These questions warrant further investigation.

Methodological Considerations

Most of the above mentioned studies used methodology that relied on caregiver self reports on their support and training needs. This could be noted as a limitation in the research literature. There may be a significant discrepancy between the perceived needs reported by caregivers and their actual needs as defined by the experiences they have in reality on a day to day basis. This issue is discussed further in the following section in relation to the actual levels of difficult behaviours manifested by children in care. However, it is worthy of note, that foster carers have been shown to evidence similar reliability in reporting children's behaviours as parents (Tarren-Sweeney, Hazell, & Carr, 2004). Foster and kinship caregivers have been shown to be more reliable than parents with depressive symptoms in reporting children's behaviours. This implies that where mental health concerns are present in biological parents, foster parents may present a more reliable picture of the reality of the children's behaviour (Randazzo, Landsverk, & Ganger, 2003). Thus the perceptions of caregivers have a significant contribution to make to understanding the support and training needs they actually require to provide quality care.

Summary

Research that reports caregiver perceptions of support and training needs show a similar range of themes. The most commonly noted issues involved access to special education and mental health services (particularly speech pathology and behavioural services); the need for emotional support during times of stress (such as during allegation processes); support dealing with birth families; respect and ongoing communication from social welfare services; understanding of social welfare policy and procedures; continuity of caseworkers and access to respite and baby sitting services (Brown & Bednar, 2006; Nixon, 1997; Nutt, 2006; Orme, Cherry, & Rhodes, 2006; Rutter, 2000; Tarren-Sweeney, Keatinge, & Hazell, In Preparation).

Recent studies have also reported the lack of external support is one of the main contributing factors to placement breakdowns (Brown & Bednar, 2006; Orme, Cherry, & Rhodes, 2006; Rutter, 2000). Difficult child behaviour was reported as another major contributing factor to placement breakdown, which gives added urgency to foster and kinship carers' perceptions of the need for more support and training in this area (Brown & Bednar, 2006).

What is clear from the reviewed research is that the quality of support and training received by foster and kinship caregivers has a huge impact not only on the well-being of the caregivers but also on the quality and continuity of care experienced by the children themselves. The findings reported in the reviewed literature seem to indicate that caregivers, in Western systems of fostering, at least, feel under-valued and under-supported. This has a profound impact on the recruitment and retention of caregivers and the stability of the placements experienced by the children in their care.

> *"Recruiting [and retaining] qualified foster parents poses a challenge for the foster care system. Sub-standard rates, changing family structures, difficult children and youth, and an agency/government structure which pays too little attention to the needs of foster parents are contributing factors."* (McKenzie, 1994)

If these perceptions are also relevant to caregivers within the New Zealand social welfare system it is essential that they are identified and provision be made within the policies and practice of CYFs to address them. It is hoped that this study will provide some exploratory ground work towards this end.

Aims of the Current Research

As already indicated the purpose of the current research has been to gather information about caregiver's perspectives of the support and training that they are currently receiving and to

investigate what further support of training they feel would be of value to them. It is hypothesized that caregivers in the current sample will report experiencing a range of behaviours similar to those in the reviewed literature and similar issues involving support and training as those identified internationally. It was decided to include a question exploring caregiver's preferred mode of training delivery due to the lack of information observed in the reviewed literature in this area. While this research is considered to provide exploratory baseline information as the basis for further, more extensive research, it is hoped it will provide information that is useful to both policy designers and practitioners. It is also hoped that the information obtained will provide baseline information that may be useful in the development of relevant training programs for caregivers in the Canterbury area. The specific procedures and questions asked of caregivers in this study are outlined in the following chapter.

CHAPTER 3

METHOD

Design

Qualitative and quantitative methods were used to gather data about the perceptions of support and training needs of a group of foster carers in a predominantly metropolitan area of Canterbury, New Zealand. It was decided to employ a qualitative method to ensure caregivers subjective experiences were included in the data gathered. This information was expected to provide greater insight into caregiver's perceptions of the support and training they receive, areas they recognize as lacking, and their priorities in accessing further support and training. The qualitative information was gathered through individual or couple interviews. It was anticipated that through participation in the interview process, caregivers would have the opportunity to voice their concerns, perceptions and experiences in a way that would enable them to take some sense of ownership for the study (Keatinge, Tarren-Sweeney, Vimpani, Hazell, & Callan, 2000). This development of a sense of ownership and shared purpose is an integral part of qualitative methodology and enhances both the quality of the relationship between the researcher and the participant, as well as the nature of the data constructed during the interview process (Cohen, Manion, & Morrison, 2003).

A domain analysis method (Cohen, Manion, & Morrison, 2003) was then used to identify common themes within the participant interviews. The six questions that form the basis of the domain analysis are detailed below and units of analysis (or themes) under each domain were constructed from the answers provided by participants. As suggested by Cohen, Manion & Morrison (2003) relationships and links between the domains were analyzed and negative cases and discrepancies identified. Following the steps outlined for this methodology possible

inferences and theories are then explored in the discussion section of this paper (Cohen, Manion, & Morrison, 2003).

The quantitative data were gathered using a modified version of the 'Assessment Checklist for Children' (ACC) (Tarren-Sweeney, In Press) and the 'Child Behaviour Checklist' (CBCL) (Achenbach & Rescorla, 2000; Achenbach & Rescorla, 2001). These measures were used to evaluate the range of behaviours that carers have experienced throughout the time they have fostered and how prepared they felt to deal with these behaviours. The Parenting Stress Index (PSI) (Abidin, 1990) was also administered to provide information on the current level of stress that the carers are experiencing in their fostering role and to gain some insight into what they distinguish as the main contributing factors to their stress. As already indicated foster carers show similar reliability in reporting children's behaviours as parents, especially where the care has been long term (Tarren-Sweeney, Hazell, & Carr, 2004). As the main focus of this paper is foster caregiver perceptions any bias that may occur through the use of self report methods are considered an inherent part of the data collected rather than a problem with reliability. The use of both qualitative and quantitative methods also provides a further check on the consistency of the self report measures.

Participants

The group targeted for inclusion in the study was foster of whänau caregivers who had fostered at least one child between the ages of birth to 10 years old. Participants for this study were recruited through the local Family and Foster Care Association and through a local, in home, early childhood education support service that works predominantly with children in foster or whänau care. Members of the both services were provided with an information sheet detailing the purpose and methods of the study (included in Appendix 1). The initial mail out included approximately 40 caregivers; some were involved with both groups. After this initial recruitment

drive nineteen caregivers indicated an interest in participating; a response rate of 47.5%. Those who wished to participate completed a consent form and were then followed up with a phone call to further explain the involvement that would be required of participants. At this stage two of the caregivers withdrew from the study.

Table 3.

Demographic Characteristics of the Participants.

Participant #	Age	Gender	Ethnicity	Occupation
1	41	F	New Zealander	Field Worker
2	53	F	European	Home Carer
3	68	F	European	Retired
4	67	M	NZ Maori	Retired
5	*	F	*	Resource Worker
6	71	F	European	Home Maker
7	47	F	European	Teacher
8	*	F	NZ Maori	Home Carer
9	58	F	*	Home Carer
10	61	F	NZ Maori/European	Residential Counsellor
11	65	F	New Zealander	NGO Social Worker
12	*	F	New Zealander	Home Carer
13	46	F	European	Home Maker
14	55	F	New Zealander	Home Maker
15	*	F	NZ Maori	NGO Social Worker
16	56	M	New Zealander	Taxi Driver
17	61	M	NZ Maori	Home Carer
Average Age: 57.62		Females: 14 Males 3	NZ Maori: 5 European: 5 Other: 7	

** Caregiver declined to provide this information.*

The remaining 17 caregivers met the criteria for inclusion in the study. Thirteen of the caregivers recruited for the study were currently caring for children. The other three did not currently have any children in their care, but all had recent extensive experience with fostering children. Thirteen of the participants were recruited through the local Family and Foster Care

Association. The other four participants were recruited through their connection with the previously mentioned Early Childhood Education Service. The demographic characteristics of the seventeen participants are listed in Table 3. The range of experience in Whänau or foster care and the number of children they have cared for is described in Table 4.

Table 4.

Participant Experience in Foster or Whänau Care.

Participant #	# Of Years Caring	# Of Children Cared For ξ	Type of Care †	Age Range Cared For	Length of Care Arrangements Experienced ‡	Agencies
1	10	10	K, F	0 – 11+	R, T, P	CYFs
2	30	100+	K, F	0 – 11+	R, T, P	CYFs, Lifelinks
3	42	15	K, F	0 – 11+	R, T, P	CYFs, Presbyterian Support
4	42	15	K, F	0 – 11+	R, T, P	CYFs, Presbyterian Support
5	39	100+	K, F	0 – 11+	R, T, P	CYFs, Open Homes Foundation
6	30	100+	F	0 – 11+	R, T, P	CYFs, Methodist Mission, Catholic Social Services
7	4	2	K	0 – 10	T, P	CYFs
8	35	100+	F	0 – 11+	R, T	CYFs, Methodist Mission, Matoa Whänau , Banardoes
9	25	100+	F	0 – 10	R, T, P	CYFs
10	35	30	F	0 – 11+	R, T, P	CYFs, Methodist Mission
11	24	100+	F	3 – 11+	R, T, P	CYFs, Catholic Social Services
12	3	10	F	0 – 10	R, T	CYFs
13	4	7	F	0 – 10	R, T, P	CYFs
14	3	25	F	0 – 11+	R, T	CYFs
15	2	5		0 – 11+	R, T	CYFs
16	3	25	F	0 – 11+	R, T	CYFs
17	3	100+	K, F	0 – 11+	R, T, P	CYFs, Lifelinks

† F in this column refers to carers who have looked after children who are not their blood relatives. K refers to carers who have looked after children who are related and part of their extended whänau.

‡ R in this column refers to respite care where the children are placed with the family for a short period of time while orders are being sort. T refers to children who have been placed in long term care with a carer but no permanency orders or plan has been made. P refers to children who are in care. The criteria for this category are that the caregivers have a permanency agreement and parenting order for the care of the children.

ξ Where caregivers indicated that they had cared for more than 100 children this has been recorded as 100+. It needs to be noted that this number includes short term respite care.

Procedure

After the initial phone contact confirming participation, a time was set to conduct the individual interviews. Participants were given the choice of being interviewed in their own homes or at the author's office. All participants except one chose to be interviewed in their own home. Each participant was given the option of having a whänau support person present at the interview and couples were given the option of completing the interview together. Participants who identified themselves as Maori were also given the option of having the cultural supervisor contracted for this study present at the interview. Caregivers were asked to nominate interview times where the children would not be present to ensure privacy and protection for the children. Prior to each interview the survey forms with an instruction letter were sent to the participants for completion (included in Appendix 1.) This was done to provide the opportunity to clarify the instructions for completing the surveys and so that the questions asked at interview could be refined if necessary when the survey results were analysed.

Interviews

Cohen, Manion & Morrison (2003) identified five features of interviews as part of research methodology. These include inconsistency between interviews due to a number of variations between relational and environmental factors; the use of avoidance tactics in answering questions that are uncomfortable; both interviewer and interviewee not offering all the information they may have on a topic; different understanding of words and their meanings; personality differences between the interviewer and interviewee; and the inability to control for every variable in a real world setting (Cohen, Manion, & Morrison, 2003). While on the one hand these features of interviews can be viewed as problematic and a threat to validity, they can also

be viewed as an inherent part of the process through which knowledge and understanding are co-constructed.

> *"The interview is not simply concerned with collecting data about life: it is part of life itself, its human embeddedness is inescapable."* (Cohen, Manion, & Morrison, 2003, p. 267)

While acknowledging these unavoidable features of the interview process, a number of measures were adopted to ensure as much consistency as possible across interviews and participants. The interview questions were kept broad to avoid influencing and constraining the participant's answers. Also the same six main questions were considered at each interview. Further questions were then asked to extend the answers provided and to ensure that the participants' meaning was clarified as much as possible (Silverman, 1993).

The questions included at each interview were:

1. What support have you experienced in your role as a caregiver for foster/whänau children from any source that you have found useful?
2. Are there other areas in which you would appreciate further support in this role?
3. What training have you accessed around fostering and caring for children while you have been fostering?
4. What other training topics would you like to have access to?
5. How could this training be presented in a way that made it most easily accessible to you?
6. What is your number one priority area of support or training that you are not currently receiving that you would like to access?

Twelve of the interviews were taped to enable detailed analysis of the domains that arose around the support and training needs of foster/whänau caregivers. Two participants declined to

be taped and handwritten notes were taken at these interviews. Each interview lasted between 40 – 60 minutes and caregivers were given the option of contacting the researcher if they had any further information they wished to include at a later date. Fourteen interviews were conducted; eleven individual interviews and three interviews with couples. The interviews were conducted in the caregiver's home with the exception of one caregiver who preferred to be interviewed at in office situation.

Surveys

The survey forms that were sent to each caregiver prior to the interview included a demographic form and the modified version of the ACC and CBCL designed for this study (included in Appendix 2). The final form sent was the PSI with some minor changes to make it fit the New Zealand context as outlined below.

Parenting Stress Index (PSI)

The Parenting Stress Index is a 120-item parent self-report questionnaire that uses a five point Likert scale (strongly agree, agree, not sure, disagree or strongly disagree). It was designed to identify parent-child systems that are under stress or are potentially dysfunctional. The language in some of the questions refers to the American School system and these were altered to reflect the New Zealand equivalent. Where a question referred to "when you brought your child home from the hospital", this was reworded to "when your child arrived." The PSI is a well recognized tool that is considered to have adequate internal consistency and test-retest reliability. The reliability coefficient for the child domain is between .70 and .83, and for the parent domain is .70 and .84, with an overall reliability of .90. The test-retest correlations were between .63 and .96 across domains and the total stress score (Abidin, 1990).

The PSI is a standardised measure for use with parents of children ranging in age from one month to 12 years and comprises of an overall Total Stress (TS) score and three Domain scores: Parent Domain (PD); Child Domain (CD); and Life Stress (LS). A Defensive Responding scale is also included. This validity scale assesses the extent to which the parent approaches the questionnaire with a strong bias to present information in a favourable light. The Child Domain is further broken down into 6 subscales. These include Distractibility/Hyperactivity (DI), Adaptability (AD), Reinforces Parent (RE), Demandingness (DE), Mood (MO) and Acceptability (AC). The Parent Domain is broken into 7 subscales, including, Competence (CO), Isolation (IS), Attachment (AT), Health (HE), Role Restriction (RO), Depression (DP) and Spouse (SP). The Life Stress domain identifies a range of external stress sources that may be impacting on the family unit, including items like a death in the family, job stresses, or relocation of the family (Abidin, 1990).

Modified Assessment Checklist for Children (ACC) and Child Behaviour Checklist (CBCL)

The CBCL and ACC are both parent report instruments designed to obtain information on a range of children's behaviours that are generally considered problematic for the children and their parents and potential indicators of clinical levels of dysfunction. (Achenbach & Rescorla, 2000; Achenbach & Rescorla, 2001; Tarren-Sweeney, In Press) Both the ACC and CBCL were used in a way that was fundamentally different from the original design. As a result of this any reliability and validity data cannot be applied to the results from this study and have not been reported.

The CBCL has been widely used in both clinical and research settings and for this reason was chosen as one of the instruments to be adapted for this study. The CBCL covers behaviours under eight syndrome scales (Withdrawn Behaviour, Somatic Complaints, Anxious/Depressed Behaviour, Social Problems, Thought Problems, Attention Problems, Rule Breaking Behaviour,

and Aggressive Behaviour) which are further organized under two higher-order factor scales: the Internalising Scale and Externalising Scale. It also includes five DSM-IV orientated scales, including, Affective Problems, Anxiety Problems, Pervasive Developmental Problems, Attention Deficit/Hyperactivity Problems & Conduct Problems (Achenbach & Rescorla, 2000; Achenbach & Rescorla, 2001).

The ACC is a more recently designed instrument that covers a range of behaviours that are not adequately measured by the CBCL and are observed among children in care (Tarren-Sweeney, In Press). It was designed specifically with children in care in mind, and for this reason was considered an important instrument for inclusion in the current study. The ACC measures behaviours across 11 Clinical Scales and 2 Self-Esteem Scales. The Clinical scales include Sexual Behaviour, Pseudomature, Non-Reciprocal, Indiscriminate, Insecure, Anxious/Distrustful, Abnormal Pain Response, Food Maintenance, Self-Injury, and Suicide Discourse. The Self-Esteem Scale includes a Negative Self-Image and Low Confidence Sub-Scale (Tarren-Sweeney, In Press).

As individual child behaviours and functioning was not the focus of this study it was decided to modify the ACC and CBCL. The modification of these instruments provided information about the sum total of behaviours that caregivers had experienced in their roles as either foster or whänau caregivers. This ensured that the anonymity of the individual children in their care was protected and provided information about the day to day behaviours that caregivers were expected to support these children with. Items that were considered representative of each of the subscales in the ACC and CBCL were chosen and caregivers were asked to indicate whether they had experienced these behaviours in any of the children they had cared for. For the behaviours they had experienced the caregivers were then asked to rate how prepared they felt to deal with each behaviour on a 3 point Likert scale (unprepared, somewhat prepared or completely prepared). (A copy of the modified ACC & CBCL and the score sheet is included in Appendix 2.)

Ethics

Prior to embarking on this study ethical approval was obtained for the methodology, recruitment of participants, and treatment of the data, from the Human Ethics Committee at the University of Canterbury, New Zealand. All participants took part in the study on a voluntary basis and formal consent was obtained from each participant. The consent procedure included providing the participants with information about their right to withdraw from the study at any stage and to request any information provided by them to be destroyed (refer to Information Letter and Consent Form in Appendix 1).

CHAPTER 4

RESULTS

Identification of themes from the interviews

Each of the 14 interviews was reviewed using a domain analysis method as outlined above (Cohen, Manion, & Morrison, 2003) The six main focus questions were considered to provide the main domains for analysis with a number of sub-themes identified under each domain. Some themes were repeated across domains giving added emphasis to the importance of these areas for participants. Each theme is detailed below as it related to the questions and example quotes are included to enable the validity of the analysis to be evaluated. Where possible percentage values have been reported for participant responses that are in agreement or disagreement on a particular theme. This has been done to provide the reader with information on deviant or negative cases and to cover the full range of responses given. At times, however caregiver's responses within a single interview were contradictory or in partial agreement and disagreement of a theme, making the calculation of percentage values in an accurate or meaningful way impossible. Where this has been the case the conflicting views have been noted and example quotes included illustrating both sides of the issue.

Question One

The most common responses to the question 'What support have you experienced in your role as a caregiver for foster/whänau children from any source that you have found useful?' were considered to be organized under the following themes:

1. ***Other Caregivers****:* All the participants mentioned other caregivers as an important source of support. The responses regarding the appropriateness of this support were varied and often contradictory, even within a single interview. Support that other caregivers provided was

divided under two main categories; caregiver support groups and individual connections with other caregivers.

Support Groups were perceived as being useful for talking over the day to day issues that caregivers were dealing with; providing social connections with other adults who are experiencing the same issues; and for providing training and speakers of interest and relevance to the particular caregivers involved. Some participants mentioned that it is hard to get out to social events because of the way their children behave and that the Caregiver Support Groups were a social connection where they did not have to feel uncomfortable about this. Concerns about these groups voiced by participants included that they often became "gossip sessions"; a lack of confidentiality and respect for the children's need for privacy; and that they became a general forum for running down CYFs and social workers which they did not seem to feel was helpful.

Individual caregiver connections were generally viewed as being a useful support resource. Support that other caregivers provide included, ideas for dealing with behaviour; support at meetings; information about entitlements and dealing with social workers and legal systems; respite or baby sitting; an understanding ear for offloading frustrations; and provision of resource ideas. Again some participants raised concerns about issues of privacy and confidentiality around discussing children with other caregivers.

Example comments include:

"I find peer supervision, like talking to other caregivers really valuable as well."

"That little group was the core of our supports. So that's where I've got the core of my support from… as far as information and everything."

"New social workers come in with their own thoughts in mind. I don't know, I know they're really busy, they don't perhaps get time to go right back and look through the files, and um, sometimes you have to have a support person there to stand up for you in another meeting."

"It's quite good to have the distance. Like she doesn't know, like (name's) family from a bar of soap. I don't know her little girl's family from a bar of soap, so it keeps it more confidential. Like whereas in Christchurch it's a very incestuous bunch of people and it seems everyone seems to know each others business and so I actually try not to. When I say peer supervision I actually tend to keep it out of Christchurch. Especially in the fostering circle, everyone knows everyone."

"Then we have support groups. We're a bit different to some 'cause we don't just sit there and run each social worker down. Some of them are good and some are, yeah well. I think it's like anything though, schools or anything, you've got to decide who you want to discuss anything with and who you don't."

"Some other foster care people, they've got kids you know, and they um keep in contact and say how's it going and that sort of thing you know. They have got the same problems that you're likely to have and you talk with them and suss things out."

2. ***Caregiver Liaison Social Workers:*** About two thirds (68.8%) of the participants mentioned that they had found the support offered by the Caregiver Liaison Social Workers to be very helpful. 18.8% did not mention Caregiver Liaison Social Workers at all and 12.5% said they had found them hard to access. The majority of participants had found the Caregiver Liaison Social Workers were responsive to phone calls, phoned on a regular basis in comparison to case workers, provided relevant and useful information, attended caregiver support groups,

provided support at meetings as required and were helpful in lobbying children's social workers.

Example comments include:

"The Caregiver Liaisons I think are really supportive. They always return the calls to me."

"We have had very good support from the Caregiver Liaison Social Workers."

"The Caregiver Liaison Social Workers, well we did have more than one but one in particular did come and actually helped with a lot of questions and subjects."

"We're meant to have a liaison social worker but I don't see mine, umm, but for the very rare occasion."

3. ***Other Support Services:*** A list of other support sources that some participants mentioned as being useful included General Medical Practitioners (41.2%), schools (23.5%), Linmark Educational Services (23.5%), the police (17.7%), Plunket (17.7%), the Lawyer for Child (17.7%), NGO Community Social Worker (5.9%), and the church community (5.9%). Around a quarter (23.5%) of participants also mentioned that extended family members were useful, whereas another 17.7% mentioned they did not find extended family supportive as they tended not to understand why they were fostering or did not like the children. Similar issues were noted around support from non-fostering friends; with 17.7% finding them useful and 5.9% mentioned a general lack of understanding from friends.

   Example comments include:

   "I've got a good family doctor who picks up on something."

   "…and Linmark have been wonderful – everyone should get Linmark."

   "…they've got to have a good lawyer."

"The Plunket nurse was good in their day. Well they still are really."

"We don't all have families, our own families aren't always supportive of what we do, you know, some families are"

"…um, if you speak to them about cultures and why are you doing it you know, and you … those sorts of questions your friends and family and they just don't understand why you are doing it, you know."

"Having that relationship with the family doctor was really important I think is for the children."

"Well families if they are interested, it depends on whether they like the kid or not and that's common, some kids are just diabolical."

"So yes, basically the school, yes they are all aware and before we start each child if they have problems we go through that and I give information to them and they if they find anything that really works they deal with it that's fine its marvellous and we have meetings at the school."

"The Church community takes the kids on board so I think if you belong to these things the children are accepted for who they are and what they are."

Question Two

Themes arising from the responses to the question 'Are there other areas in which you would appreciate further support in this role?' included:

1. ***Children's Social Workers:*** One group from which most participants indicated that they would appreciate more support, was the Children's Social Workers. Approximately two thirds (64.7%) of the participants mentioned that they had problems with Social Workers, 29.4%

mentioned that they had problems with some Social Workers but found others good and 5.9% said they found their Social Worker responsive and supportive. Issues with the support received from Social Workers included, lack of responsiveness to phone calls; lack of information around legal issues such as additional guardianship; lack of respect for the caregivers role; and inconsistent application of procedures.

Another problem area frequently (82.4%) mentioned by participants in regards to Social Workers, was a lack of communication. Participants mentioned frustration at not being informed of changes in contact arrangements, lack of communication about the child's background (including basic medical information) and a lack of provision of care plans. High turn over of case workers was also mentioned as common factor that impacted negatively on participant perceptions of support. They felt that new case workers often made poorly informed decisions based on insufficient familiarity with the children's care history. While most participants indicated an understanding of the pressures that Social Workers are under and how the growing size of their caseloads impacted on their ability to be responsive, they expressed frustration at the lack of support provided by CYFs Social Workers.

Example comments include:

"The best thing you can do for a child you take into your care is to dump CYFs and especially for grandparents raising grandchildren."

"You know, you ring the social worker and it will take five weeks to get hold of her, and that's another issue."

"Some of the social workers are very good, some are not. Um and, ok I know they can be overstretched and over worked but… um…then again the social workers I've got, I don't care if I don't hear from them."

"Initially when a child comes into your home, it depends on the on the social worker, some are very good. Give you quite a good back ground. Some don't they just drop and run and you know, when you're dealing with all the different emotions if you were given a bit more feedback you'd be able to deal with the situations a bit better, if you know what they've been through.

"Yeah I think it's important that you're given as much information as possible, so you know what you're dealing with, you know. Then you can make plans to cater for it."

"It's generally from the social worker. One of them's really good. Like she tells me about all the activities allowances which was good. I thought, all this I've been paying for them, and I could have… Yeah so that was good."

"We had (office) CYFS involved before the children were removed, um as support and guidance of what we did in the family for probably up to a year before that happened, they were really great, and then stepped in when we needed them too and they have always been really responsive, always available, Social Workers have been great, always given us the information that we needed which I think was really important."

"The one that we had was always sick, she was never there, 3 days off sick, away on holiday or not there and sick."

"Social workers being more on hand when the kids are here, a phone call saying how has so and so been this week? I can't get out this week so thought I'd ring you up blah blah blah – no nothing they drop the kids here and that's it finish."

"Probably sometimes social workers not so much support um less change of social worker is probably the biggest yeah the continuity."

2. ***Access to Specialist Health & Education Services:*** Nearly two thirds (64.7%) of participants mentioned difficulties with accessing special education and health services. Difficulties accessing these services were attributed to Social Workers failing to follow through with referrals, lack of funding provision from CYFs or generally long waiting lists within the services themselves. 5.9% of participants did not mention specialist services at all and 29.4% felt happy with the specialist services they had accessed. Another theme associated with access to specialist services included support with the day to day behaviours of the children. Just over half (58.8%) the participants mentioned that they would appreciate more support in dealing with the behaviors they encountered in the children they cared for on a day to day basis. This was also a common theme mentioned in areas where they would appreciate more training (more details noted below).

   Example comments include:

   "These two particular children definitely needed mental health services that we've been trying to get them on for years. Doctor's been trying to get them pushed through but it got stopped at Child, Youth and families because of expense."

   "There's a lack of funding and lack of, yeah, the um, the system has got so bad that there is less qualified staff to deal with it. As in there is too few psychologists, to few, yeah, to few specialist help for children with behaviour problems."

   "Sometimes it takes many, many months and you know, even to progress on from the likes of the Counsellor, to the likes of say Youth Speciality Services for the older children, um sometimes they won't take a child on till there's been a strengthening family's meeting and that strengthening family's meeting you can wait, you know, something like 3 months, you know, like before Youth Specialties will actually come on board and put in place what the psychiatrist and the counsellor or the doctor has suggested. You know and sometimes it can

take 3 months or sometimes when the child has been sexually abused it can take years, before… and even then, the Social Workers, you know I know of children who have been sexually abused now, but they are not actually doing anything about it."

3. ***Allegations:*** Dealing with allegation investigations was another area that some participants mentioned where they felt the need for more support. Out of the 29.4% who raised this issue, all felt that further support in this area would be helpful. 11.8% mentioned a handout that had been created by the Foster Care Federation as being helpful. The general feeling seemed to be that Social Workers generally provided little information and sometimes added to the stress of allegation investigations unnecessarily. All the participants that mentioned this area indicted an understanding that investigations needed to be carried out where allegations were made, but felt that responses were inconsistent and often outweighed the seriousness of the allegation. Also related to this theme, around a quarter (23.5%) of the participants mentioned the new pilot scheme that has been set up by the Foster Care Federation and CYFs to support caregivers with allegations. In early 2006 a small number of experienced caregivers were provided with training in helping caregivers through allegation investigations. The participants that mentioned this scheme felt that it was already making a difference for some caregivers and that it had the potential to be very effective.

   Example comments include:

   "These kids can say what they like about you, say five years down the track with young (name) and he says "oh mum hit me." I'd be gone. There is no protection for caregivers against these kids and some of them…Yeah!"

   "There was no support on allegations before this." (Referring to the pilot scheme.)

"For themselves it would be how to keep yourself safe, for the new foster parents against allegations I think that would be a big thing and how to get a hold of your social worker."

"Some of these allegations they investigate are just stupid – I know they've got to investigate but the way they go about some of these, I suppose you can't criticise – I would classify one it would probably be a minor one. Take the allegation that I am on at the moment it is ridiculous to some other allegations, before the scheme came in supported people that are upon allegations, the one I'm on at the moment is utterly and totally ridiculous."

4. ***Respite care/Babysitting:*** Another common theme revolved around participants needing to have a break from time to time from the children either through respite care or one off outings requiring a babysitter. While all the participants who mentioned this area (52.9%) wanted more support and access to babysitting and respite services, a number of them also mentioned that this posed difficulties for them. They did not feel able to leave the children with strangers, for example, or take them to other people's houses for respite. While they indicated a need for a break now and then, some participants felt that the children had so many changes in their lives already, that it was not appropriate to add to them. Another problem mentioned in this area revolved around the children's behaviour. This was often linked to cost of accessing baby sitters. Where participants had more than one child with difficult behaviours, they mentioned finding it difficult to find sitters willing to look after the children, and then felt that they had to pay them extra for the number of children they had or the difficulty of the behaviours.

   Example comments include:

   "I think more respite would be a really good thing. Doing this alone is quite tiring."

"What do I do with her while or go, or what do I do with the other ones – that's another night you have to pay a baby sitter. Not easy to get a baby sitter for a 13 year old – they have to have a Police report done and they have to be a certain age and you know …. Very hard."

"Carers are looking after children that they don't want to leave, especially with strangers you know, and they can't use family…"

"One of the biggest problems for the group that I am part of round here is that we have no sitters, and if we want to go out, like I go to a Church Home Group on a Thursday night, and I never went for months and months."

"I pay a sitter to come in, I have to otherwise I wouldn't um and if I do go out with a friend about once every 2 months to a movie that's about the sole social life that I have. Some people have 4-5 foster children and the more you have the harder it is."

5. ***Supervision/Counseling****:* 70.6% of the participants mentioned that they would appreciate some form of organized supervision or counselling. The remaining participants (29.4%) did not mention this area at all. Reasons that this was considered to be useful included, that it protected children's privacy and would be more confidential than casual caregiver contacts. Other reasons for wanting formal supervision included, dealing with allegations; support with birth families (particularly for whänau caregivers); an ear to offload the *"emotional crap"* the children present with; and support with dealing with CYFs systems. One suggestion for this supervision or counseling included an organized buddy system where new caregivers are paired up with an existing experienced caregiver. Another participant felt it was important that this was conducted outside CYFs, as she felt some anxiety about the children being removed if she was perceived to be "not coping." The frequency of supervision/counselling

for caregivers was also mentioned by some participants. These suggestions varied from regular quarterly to six weekly sessions to an 'as needed' system.

Example comments include:

"When it's day after day and your house is getting more and more trashed it is good to have someone to talk to. It wouldn't have to be that regular, like once a month or something, but just knowing that it is there."

"I think whänau carers need, um whänau carers need a facility for counselling, and I think foster carers need supervision – does that make sense? Yep, I think whänau carers definitely need that and um when its not there yeah, 'cause you are dealing with lots of issues and need some help with that."

"I think again that foster carers need supervision and whänau carers need counselling and/or supervision but certainly a place to put things."

"There is a lot of needs and a lot of stuff going on and where do they put that and there's confidentiality involved, I mean, you know if they want things to remain confidential and people to get the right protection, they need to provide supervision for them, with an impartial person you know, without… they… supervision would be marvellous for carers."

"And I think the other problem is that foster parents need someone on the ground to be able to ring and CYFS… for the first 2 years they need that supervision."

Question Three

The responses to the question 'What training have you accessed around fostering and caring for children while you have been fostering?' indicate that:

1. ***Induction training:*** Just over half (58.8%) the participants had completed the induction training provided by CYFs and generally commented that they found it provided useful basic

information. Of the remaining participants 5.9% did not mention the induction training at all. Around a quarter (23.5%) of the participants stated that they had started caregiving prior to the induction training being made available. The remaining 5.9% had not completed the training as they were whänau caregivers and did not feel it was relevant.

The specific areas that participants found useful were as diverse as the participants themselves, with no clear themes evident. Areas that the participants would have liked more information on were also diverse, although dealing with birth family contact, child behaviours and CYFs and legal systems were the most prevalent. The most commonly mentioned issue around the induction training revolved around the usefulness of hearing other experienced caregivers talk about the realities of caring for children. Responses from participants on this differed depending on when they had completed the training. It appears that having an experienced caregiver speak at one of the induction training evenings has, at times, been common practice. 70.6% if the participants either thought that this was the best part of the training or felt that this should be included in the training. This was an important issue even for caregivers who had not completed the induction training, and provides possible supporting evidence for other themes such as participants wanting to be heard as, and respected by, professionals.

Another theme in relation to the induction training that was mentioned by 29.4% of participants was the issue of its relevance to whänau caregivers. The induction training is not currently compulsory for whänau caregivers and as mentioned 5.9% of caregivers did not feel it was relevant. Close to a quarter (23.5%) of participants mentioned this issue and felt that the induction training should be compulsory for all caregivers, including whänau caregivers. To provide some contextual information around these responses, the participant who felt the induction training was not relevant for whänau caregivers, was a whänau caregiver. The 4

participants who felt that is should be compulsory for all caregivers were all participants who had provided both whänau and foster care.

Example comments include:

"They go through all like safety issues and that kind of thing. They go through the basics. It needs to be upgraded."

"All people going into whänau caregiving should be made to do the induction courses, and all other courses aw well."

"I think if they gave some more caregivers, if more caregivers went along and told it how it really was it would be quite useful."

"Listening to the other foster parents that were there at the end, you know they would say lots of different things about what to do. But you know it was good. Good to be with other people who were venturing on, you know the same journey that we were."

"I wish they had given us some more about the problems we would encounter, especially about children with emotional problems."

"Um I suppose it well the things that the other foster parents said there at the end you know different things that they do and don't do ... well actually .....you know ... you are not actually always there for us, but well OK - but I thought that was pretty good. It was good to be amongst other people that were facing the same things that we were so…"

"They would have to be compulsory or some sort of semi-compulsory or something because I don't think unless it was specified at the induction course that you must attend like 2 trainings a year, I don't think people would go."

2. ***National Training Modules:*** 29.4% of the participants had not attended any of the eight national training modules provided by CYFs in conjunction with the Foster Care Federation. All of these participants stated that the timing and availability of these courses was a major factor in their decision not to attend. One participant (5.9%) mentioned that she had enrolled for a module and had then not been able to attend as it was cancelled. Of the remaining 70.6% of participants, roughly a third (35.3%) had attended seven or eight of the modules and the remaining third (35.3%) had attended between three and six of the modules. With the exception of one (5.9%) all the participants who had attended the training thought that they provided useful information, though many felt it was at a fairly basic level. The one exception (who had completed all eight modules), stated that the information was not always relevant, but that the networking opportunity was important and useful. The importance of networking at training events was noted by nearly a quarter (23.5%) of the participants.

   Even among the participants who had attended training modules, a common theme (35.3%) was the difficulty of getting to them. Issues around attending training included timing, location and child care. Three caregivers mentioned driving to other towns (e.g. Timaru or Dunedin) to attend training modules that had not been offered in the local area. Another area of concern for participants around the national training modules was the lack of recognition it gained them with social workers. This lack of recognition they felt was also evidenced in the recent failure of trainers to issue certificates when modules were completed. Example comments include:

   "Done all their units, maltreatment, the lot."

   "Done most of the training modules. I've got three to do and I've only got three to do because they haven't come to Christchurch."

"Well I suppose most useful has been, you know how they've run, CYFs and the foster care have run, the courses, there's seven of them. They have been useful and I think if more foster parents actually did them, or went along, ok they might not be thinking they'll be getting a lot out of the course, the problems that come up for discussion though, half their problems would be solved."

"No I haven't because um the age of the children this time… but I do intend to do some."

"I've attend the courses, what's it called, the course like behaviour management, non-violent crisis intervention, family dynamics, that was interesting um, a series of eight."

3. ***National Certificate in Whänau/Family and Foster Care:*** Three participants (17.7%) indicated that they had enrolled in the pilot intake of the recently developed National Certificate in Whänau/Family and Foster Care. One then dropped out due to the course not being what was hoped for and the time commitment involved. All three of these participants mentioned that the information covered in the course was the same as that covered in the national training modules. The two who remained enrolled in the program both indicated that the Certificate being offered to caregivers and the qualification when gained provided them with recognition of the importance of their role. Two further participants from the current study (11.8%) indicated that they were interested in enrolling for this training at the next intake.

   Example comments include:

   "I'm doing the national certificate. It's going well. Its very time consuming to put in the hours I need to. It's a bit repetitive but it will be good to have a qualification at the end of it.

   "I started it, let it drop. No use to care givers – what is it going to give us, caregivers, absolutely nothing. They'll give you a slip of paper that say you have completed the Diploma

in Care Giving blah blah blah – you are qualified – you are no more qualified than Jo Bloggs down the road going and sitting it – so the content wasn't so great. All the courses that we have already done, we have now done in the contents of the exam. The first one they were working on was all to do with maltreatment. Now I could come home get my maltreatment book and copy all the answers out of there. You are not learning anything new – just the same old, same old courses that you do. If they give a Diploma for that reasons – why don't we get it for courses we have already done. If they are going to do it why aren't they doing something new?"

Question Four

The most common themes identified for the question 'What other training topics would you like to have access to?' were:

1. ***Legal & CYFs System Information:*** A number of participants mentioned that they would appreciate further information about how to navigate the CYFs system and about their legal rights as caregivers. Particular topics of interest mentioned under this theme were, permanency (particularly in regards to the Care of Children Act 2004 and Parenting Orders (35.3%); navigating health, education and CYFs department structures (35.3%); and allegation procedures (29.4%). Another area relating to this domain that some participants (17.7%) mentioned a need for further training, included issues where foster children's legal status resulted in differences in caregiving compared with the participant's own children. One example was that CYFs policy states that people who are caring for foster children need to be police checked, including anyone that the children will stay overnight with. Some participants noted that this meant that they could not let foster children stay overnight at a friends place without first getting permission from a social worker. Participants seemed to indicate that the difficulties in making contact with social workers meant that, in reality, foster children were

either missing out on these normal childhood activities, or that caregivers felt that they were 'breaking the rules' if they went ahead and allowed them. Participants indicated that they would appreciate further training in both, how to explain to foster children why they couldn't do certain things that their own children could, and where the boundaries are around decisions allowing the children to do these kinds of things. Other examples of this issue included how to teach children about stranger danger when they were frequently picked for contact visits by strangers, hugging policies, and what to let children call them (e.g. mum, aunty, Nana or by their first name.)

Example comments include:

"And this is where the problems are coming in, there are things that (name) is allowed or not allowed to do because of CYFS that the others can do– like visiting friends - the rules are different and they shouldn't be allowed to be. Last night he was happy, one of his friends came and stayed – he was happy. His friend can come to our house, but (name) can't go to his friend's house over-night or for a few hours after school till these people are Police checked. It is an anomaly – we bend the rules. They need to put something into their induction thing that covers sleep-overs."

"More on permanency. I think additional guardianship is good but I wouldn't go further. I think it's a good thing to be able to choose their school and whether to take them to church or not."

"And just things like what do the children call you? And how do you deal with that – and they have to wake up to a 'Mummy' but you're not really Mummy, but you want them to wake up to one, just those sort of things and you have to deal with them but you're not really sure what to do with them, so I think that would a brilliant thing to offer to carers."

"How to deal with school situations, primary school processes to go through, big issues round education, and how to work the health system. Practical stuff how to get access to that extra support usually needed but falling through the gaps."

"There's no written information about permanency and the pros and cons and very little verbal information available."

2. ***First Aid:*** Just over a half (52.9%) the participants indicated that they would like first aid training. The other participants did not mention this topic. Again this issue seemed to be tied up for participants in recognition of their roles. Participants mentioned that other human services employees would receive first aid training as a matter of course and felt that they should be accorded the same recognition.

   Example comments include:

   "First aid, yeah, the first aid, so one of them was the OSH one."

   "And I've always believed social workers, ah not social workers, caregivers on these induction courses; every caregiver should have a first aid certificate. Nobody… its not one of their priorities. I brought it up nearly 2 years ago but still haven't done it."

   "First aid, they should be getting that as a matter of course, but I think I've got enough first aid."

3. ***Birth Family and Contact Visits:*** 29.4% of participants indicated that they would like further training around how to deal effectively with birth parents and managing a number of issues around contact visits. These issues included children's behaviour after visits; children's disappointment when parents cancelled; how to supportively manage children who did not

wish to attend contact visits; and how to answer children's questions about birth parents (e.g. why they are in care and why can't they return home.)

Example comments include:

"Um I think a lot of foster parents get their backs up when you mention birth parents, and I think some sort of training to handle, to put it into perspective… because, no matter what they are they still, I don't care who their trustee… I don't care who has guardianship, they still belong to their parents and they love their parents regardless, even though these parents are doing things I don't like, they don't pick it up from me, you know I … especially when they had to come back into care I felt very hostile towards them, but you've still got to carry on and I think for the kids to feel comfortable in foster care, you've got to, even though you don't want to, you've got to be seen to be getting on with those parents – so some training – I mean they could have physically hurt them and you think 'how could they do that?', but they are still their parents and you've got to get over that, and try and keep that connection with the kids"

I've seen other children that have been very distressed and um, they are unhappy to come back 'I don't want to be here I want to be with my Mum' I think that would be quite difficult. It's not suitable for the children to be with the parent, and what do you say? 'It's not safe for you to be with.' What they have done and what they haven't done. You would like to sit them down and say 'Well look" but you know that you can't. So what do you say?"

4. ***Difficult Child Behaviours:*** 70.6% of the participants indicated that they would like to access further training around difficult child behaviours. 41.2% of the participants indicated that they would like training around the specific behaviours they are experiencing with the children that they currently have in care, rather than more generalised behaviour management

techniques. Just over a third (35.3%) indicated that they would like more information on why the children were behaving the way they were, i.e. understanding how children's backgrounds influence their current behaviours. In a related area nearly a quarter (23.5%) of participants mentioned that they would like information on how disrupted attachment impacted on children's behaviour and how they could support foster children to develop secure attachment systems.17.7% of participants indicated that they would like training on children's behaviour to incorporate information on normal and abnormal developmental patterns. The general reason given for the inclusion of this information was so that they would know what was within the realms of 'normal' development and what they needed to be concerned about.

Example comments include:

"Well managing behaviour, but more one on one behaviour training for managing the specific child you have would be good."

"Its always around behaviour management, um, attachment, behaviour management is a huge one I think for carers."

"It would probably be behavioural. Like 'specially now as they are getting older and I was told that when they reach about 7 they start to get more difficult."

"They do some quite atrocious behaviours, and um, I've had them recently using the laundry baskets full of clothes as a toilet, you know, um yeah, there are some quite atrocious things that children do, and um, sure you know you tell them off to a standstill, and tell them that its not acceptable and not appropriate and you know, but half the time they don't even know why they do it, you know, there's all this sort of thing and you know… those sort of things are really hard to deal with, and there's, you know, the damage to your house you know."

"Training around how the behaviours occur so foster carers don't think it's all their fault."

"I think that learning stages of development and being able to identify where the kids are in the those stages is absolutely essential, and I don't think that is part of any training, and if you don't where you kid is in the stage of development how can you talk with the professionals on where your kid is at."

"But you need some form of actual on hands training, I think you really do. Because we weren't trained to be to deal with mentally ill, I mean when you say mentally ill I don't mean in a horrible way I mean like ADHD and alcohol foetal syndrome and all that, most people that go in as caregivers don't haven't produced even children like that. Really important."

5. ***Bicultural and Multicultural Issues:*** 17.7% of participants indicated that they would appreciate training around issues of bicultural and multiculturalism. Specific topics mentioned included basic Maori and Pacific Island language phrases; how to support children from different cultures from their own; dealing with whänau from a different culture and how the Treaty of Waitangi impacts on their role.

   Example comments include:

   "I haven't actually done any cultural training on the Treaty, although I got a copy of the Treaty of Waitangi and read and know what it is all about, I've never actually attended any training. I have 2 adopted children of multi-cultural background and um you know I did attend groups with them when they were children but now they are adults of course and the foster children are quite often children from other, um like the little boy that I've got now is Maori, Samoan and Pakeha so although he is white skinned and doesn't look it, His facial features are Samoan but he hasn't got any colour or anything and we have to look at what were going to do with him and his brother as far as cultural experience is concerned so um and really I haven't… I did attend an introductory Maori course at one stage but that was a

long time ago but I would have liked to attend a Treaty of Waitangi training, and something in the cultural line.

"I'd like some training in basic reo and Samoan words. Just so I can tell the kids… you know, keep in touch."

6. ***Caregiver Health**:* How to look after their own physical and mental health was another area in which roughly a third (35.3%) of the participants indicated that they would appreciate more training. The most commonly mentioned topic related to this theme was information around dealing with grief and letting go when children returned to their birth families (23.5%). Other topics related to this theme included safe practice to avoid allegations; self care when respite was not available; relaxation techniques and dealing with their own emotions around birth families without letting the children know what they are really feeling.

   Example comments include:

   "And I think the other one is self-care, taking one step back, taking 5 and just walking around the block, getting out of the situation, relaxation techniques, those sorts of things."

   "The other one that has cropped up last year was one about grief management and I think it will pop up in fostering care if you give the child back home to let go which is a huge thing for the kids and the foster parents."

   "And very tactful you know. It is, but its mixed emotions, too you get frustrated and angry with some of the parents but you have got to, think of the child, because when they go to see them you know, they are happy and when they come back."

Question Five

Themes arising from the responses to the question 'How could this training be presented in a way that made it most easily accessible to you?' included:

1. ***Timing:*** One of the main themes indicated in the responses to this question was around the timing that training was offered. 82.4% of caregivers mentioned of this. Around half (52.9%) the participants indicated that between school hours would be their preferred time for training as it meant that childcare was not such a problematic issue. A further 17.7% indicated that weekends would be their preferred time for accessing training. The remaining participants did not mention timing as being an issue for them or did not specify a preferred time.

   Example comments include:

   "When these courses do come up, we can't get to them. It's alright if they can run them between say nine and two so people can get home for children."

   "Where as for caregivers, um, it would be better through the day. Like 9.30 'til 2.30 when you can access pre-school."

   "School hours would be better. It's amazing what you can do during school hours. You can go to all sorts of groups."

   "Best courses they have run are between 9 and 3 or 5 – 9 pm on Friday night then the day after the Friday, Saturday ones because then you haven't got the problem of someone having to be home to go down and get the kids from school, get in a baby sitter or someone has to go and do it for you …. I think the courses have to work round the care givers being able to take the kids to school and make them like. See like they say on these courses they say you can be paid baby sitting, fees but it's never done. There is never any money available for you to pay a baby sitter – lately you don't even get your certificates."

2. ***Baby Sitting:*** Nearly a third (29.4%) of the participants indicated that arranging child care was a major factor that impacted on their ability to attend training sessions. These participants all mentioned that the current babysitting allowance provided by CYFs to enable caregivers to attend training was insufficient to cover expenses. The most common figure quoted for the baby sitting allowance was $50.00. Participants indicated that was to provide babysitting for around two days and was not altered to reflect the number of children they had in care.

   Example comments include:

   "Well some of it is in the evening and when they only fund fifty dollars for however many children you have in your care. Fifty is actually not much for someone to look after three children for two days, well you know a Friday night right through Saturday afternoon."

3. ***Alternative Training Formats:*** Roughly half (47.1%) of participants indicated that they would be interested in alternative training formats that enabled them to access training options in their own homes. Some of the formats suggested included computer based training (17.7%), correspondence training (11.8%) and one to one training in their own home (5.9%) A further quarter (23.5%) of the participants mentioned alternative training options but felt that options that encouraged caregivers to study at home would not be as valuable as group options. These participants seemed to indicate that for them the networking and exchange of ideas among caregivers was one of the most valuable components of accessing training.

   Example comments include:

   "I've got the computer and I've got email and everything on line, but a lot of people don't have computers, so I'm just trying to think of the group that I know, 1, 2, 3 … probably about half would have computers, but I know it could be online and whoever is facilitator of the group was could print it off and certainly give a copy and use it at support groups and see

that everybody had a copy and sort of say 'Well here's some good value stuff.' So that sort of would be a possibility to see that the people who didn't have computers got it as well, and could do it at their own pace and time"

"You change (name) routine and everybody look out. So I do that at as little as possible. So if they offered it through correspondence or the computer that would be a help because you could do it in your own home and come together at night, or something like that. Even Saturdays are chaotic here and Sunday, so if a little group of you, that were doing it and met together once in a while."

"I spend a lot of time on the computer, but even then… No I don't think so 'cause you miss out on talking to everyone and all the ideas and bouncing things around."

4. ***Location:*** The location in which the training was to be held was another theme that arose from this question. As already mentioned nearly half (47.1%) the participants were interested in training that could be accessed in the home. A further issue relating to this was that some of the training modules had not been available in the local area for a number of years, meaning that caregivers who wished to complete all eight national modules had to travel to other centers. 17.7% of the participants indicated that it was important to them that training was offered in their local area, as this made it more accessible to them.

   Example comments include:

   "It would be helpful if they were held in local areas."

   "You can't expect foster carers to go down to Timaru to attend a course. And this is what … but you can't expect foster carers to do that, and the hours they run them are inconvenient."

Question Six

In response to the question 'What is your number one priority area of support or training that you are not currently receiving that you would like to access?' three main themes arose. The details of these themes are not included here as they have been comprehensively covered under the preceding questions. One participant (5.9%) was not asked this question. The most common response to this question was the difficult behaviours that the participants experienced on a day to day basis. 64.7% of the participants indicated this was the area of highest priority in which they wished to access further support or training. The next most common area was around dealing with birth families and contact visits, with 17.7% of participants rating this as their main priority. The final area mentioned in response to this question, involved legal issues such as permanency, allegations and guardianship (11.8%).

Results from the PSI

PSI data were obtained for 13 participants. Three participants were not asked to complete this scale as they were not currently caring for any children. One other participant did not return the questionnaire so it was not possible to include their data in the analysis. Table 5 shows the results for each participant across the child, parent and life stressors domains and the composite total stress score. The normative data are also presented so comparisons can be made (Abidin, 1990).

These results suggest that the participants in this study are experiencing an average overall stress score within one standard deviation higher than the normative sample. The average score for the Parent and Life Stressors Domains both fall within the normal range. The average Child Domain Score however, falls two standard deviations higher than that reported for the normative sample. While the normative data was gathered for an American sample they provide a

useful guide for the interpretation of the data obtained from the current sample. Further analysis of each of the sub-scales within the Child Domain show that the average raw score across all these scales, fall in the high to clinical range, with the scores for Adaptability, Reinforces Parent, Demandingness, Mood and Acceptability falling two standard deviations above the norm (See Table 6).

Table 5.

Mean Participant and Normative Domain Scores from the Parenting Stress Index.

Participant	Composite Score †	Child Domain ‡	Parent Domain ξ	Life Stressors	Defensive Responding ψ
1	280	166	114	4	29
2	230	105	125	14	36
3	270	138	132	4	37
4	266	126	140	4	41
5	310	166	144	22	35
6	201	124	77	21	16
7	193	70	123	20	34
9	190	104	86	4	22
12	281	162	119	6	30
13	291	135	156	9	46
14	308	140	168	4	46
16	238	133	105	6	31
17	254	127	127	18	41
Mean Score (S. D.)	254.77 (41.51)	130.46 (27.04)	124.31 (25.54)	10.46 (7.39)	
Range	190 - 310	70 - 166	77 – 168	4 – 22	
Normative Mean Score Ж (S. D.)	222.8 (36.6)	99.7 (18.8)	123.1 (24.4)	7.8 (6.2)	

† Composite Scores are considered high if they have a Raw Score Value above 252. Scores above 258 are considered to be in the clinical range.
‡ Child Domain Scores are considered high if they have a Raw Score Value above 114. Scores above 116 are considered to be in the clinical range.
ξ Parent Domain Scores are considered high if they have a Raw Score Value above 142. Scores above 148 are considered to be in the clinical range.
Ψ A Defensive Responding Score of 24 or less indicates that the participant is likely to have presented a picture that is better than is in reality the case. Results that indicate a high level of defensive responses should be interpreted with caution.
Ж Normative data taken from Abidin, 1990.

Table 6.

Mean Participant and Normative Scores for the Child Domain from the Parenting Stress Index.

Child Domain Sub-scale	DI	AD	RE	DE	MO	AC
Mean Raw Score (S.D.)	28.23 (6.31)	33.31 (7.94)	14.77 (5.09)	23.08 (7.66)	13.62 (5.22)	18.23 (4.85)
Range	14 - 36	24 - 45	6 - 23	9 - 33	5 - 24	7 – 24
Normative Data † Raw Score (S.D.)	24.7 (4.8)	24.9 (5.7)	9.4 (2.9)	18.3 (4.6)	9.7 (2.9)	12.6 (3.5)

† Normative data taken from Abidin, 1990.

Results from the Modified ACC/ CBCL

Data was obtained from 16 participants with this measure. One participant failed to return the questionnaire after completion of the interview. Results from the modified ACC/CBCL showed that on average participants have experienced around 54 – 55 of the behaviours 114 surveyed (refer to Table 7). These findings suggest that most caregivers have encountered most of the difficulties manifested by children in care. Participants reported an overall average preparedness score of 1.38 (refer to Table 7). On average the participants indicated that they felt somewhat prepared, rather than completely prepared, to deal with the behaviours they experienced on a day to day basis.

Table 7.

The Number of Children in Care, Behaviours Experienced and the Mean Level of Preparedness of Participants.

Participant	# of Children Cared For	# of Behaviours Experienced (n=114)	Mean Level of Preparedness
1	10	78	1.09
2	100+	86	2
3	15	47	0.53
4	15	47	0.85
5	200+	82	1.73
6	175+	24	2
7	2	29	2
8	100+	71	1.35
9	100+	19	1.11
10	30+	43	1.95
11	120	85	1.46
12	10	15	1
13	7	78	1.53
14	25	41	0.95
16	25	40	0.85
17	100+	85	1.74
Mean	25.44	54.38	1.38
Standard Deviation	36.27	25.85	0.49
Range	2 to 200	15 to 113	0.53 to 2

Bivariate Pearson R correlations were calculated to gain some information on the relationship between caregiver's feelings of preparedness in dealing with the behaviours they had encountered and areas that can be considered to reflect participant's experience. Participant's experience is reflected in the number of children they had cared for, the number of years they had been caring, the number of behaviours they had experienced and the number of training modules they had attended. Only very weak correlations were reported between these areas and caregiver's reports of how prepared they felt in dealing with the children's behaviours they had encountered. None of the reported correlations reached above .35 or came close to approaching significance with the exception of the correlation between the number of training modules attended and the average level of preparedness reported (refer to Table 8). The effect size for the

relationship between preparedness and participation in training, expressed as the variance accounted, was 0.16 ($r = .394^2$). This was not statistically significant. There was insufficient statistical power to detect meaningful (i.e. above r = 0.3) correlation co-efficient because of the small sample size.

Table 8.

Correlation between Caregiver Experience and their Reported Level of Preparedness in Dealing with Difficult Child Behaviours.

	# of Years Caregiving	# of Children Cared For	# of Difficult Behaviours Experienced	# of National Training Modules Attended
Level of Preparedness	.122	.119	.244	.394
Significance	.653	.760	.362	.183

CHAPTER 5

DISCUSSION

In support of the original hypotheses, the results from this study were largely consistent with the literature reviewed. There were however, a small number of themes that arose which seem to be specific to the Canterbury context. It needs to be noted, that given the small sample size, care should be taken in interpreting the results of this study and in their application across the general population of caregivers in the New Zealand context. This section will initially detail the similarities and differences between the current and reviewed research. The limitations of this study will be noted and suggestions for further research will be covered. Consideration will be given to the implications of the current research for social work practice and the development of training for foster and whänau caregivers in the New Zealand context.

Comparison with other Studies

Themes covered by the participants during the interviews largely reflect the range of issues identified in other studies (Brown & Bednar, 2006; Gordon, McKinley, Satterfield, & Curtis, 2003; Hudson & Levasseur, 2002; Jones & Morrissette, 1999; Nixon, 1997; Nutt, 2006; Tarren-Sweeney, Keatinge, & Hazell, In Preparation). These include; a perceived lack of respect from social services staff, particularly children's case social workers (Gordon, McKinley, Satterfield, & Curtis, 2003; Hudson & Levasseur, 2002; Jones & Morrissette, 1999; Nutt, 2006); difficulties with understanding and managing children's behaviours (Hudson & Levasseur, 2002; Jones & Morrissette, 1999); lack of communication and responsiveness from social services staff (Jones & Morrissette, 1999; Nutt, 2006); tension arising from both the children's and the caregiver's contact with birth families (Hudson & Levasseur, 2002; Jones & Morrissette, 1999; Nutt, 2006); perceptions of exclusion from decision making processes (Gordon, McKinley,

Satterfield, & Curtis, 2003; Hudson & Levasseur, 2002; Jones & Morrissette, 1999; Nutt, 2006), difficulties accessing specialist services (Hudson & Levasseur, 2002; Jones & Morrissette, 1999); the need for supportive and non-judgmental supervision (Hudson & Levasseur, 2002); difficulties for caregivers in understanding legal processes and social service practices (Gordon, McKinley, Satterfield, & Curtis, 2003; Jones & Morrissette, 1999; Nutt, 2006); access to respite care and baby sitting (Gordon, McKinley, Satterfield, & Curtis, 2003; Hudson & Levasseur, 2002); access to training relevant to caregiver's specific contexts (Hudson & Levasseur, 2002) and recognition of caregivers' role by social services staff and other professionals (Hudson & Levasseur, 2002; Nutt, 2006; Pacifici, Delany, White, Nelson, & Cummings, 2006). The implications of these findings for social work practice and training delivery are further explored below. These findings provide only preliminary exploratory information and need to be replicated across a larger sample group. However they reinforce the commonality of foster carer's experience, concerns and perceived needs, throughout the western world.

The present study also identified additional or novel themes, which may be specific to Canterbury or New Zealand. This disparity may reflect differences in the structure of social welfare departments across international settings. The majority of caregivers in the current study, for example, indicated an appreciation of the support provided by Caregiver Liaison Social Workers. Not all social services departments have social workers who are expressly contracted to provide support for caregivers and this accounts for the lack of mention of this in the reviewed literature. The implication of this finding is that the incorporation of Caregiver Liaison Social Workers into the structure of the New Zealand social welfare system is a strength. These social workers, at least in the Canterbury area, are viewed positively by caregivers and are seen as a responsive and useful support source. This contrasts with the negative perception about caseworker support both in the current study and the reviewed studies (Brown & Bednar, 2006;

Gordon, McKinley, Satterfield, & Curtis, 2003; Hudson & Levasseur, 2002; Jones & Morrissette, 1999; Nixon, 1997; Nutt, 2006; Tarren-Sweeney, Keatinge, & Hazell, In Preparation).

Also highlighted in the responses in the current study was the importance of the support provided by other caregivers. While in most of the reviewed studies caregivers voiced a need for an understanding ear to offload concerns to (Gordon, McKinley, Satterfield, & Curtis, 2003; Hudson & Levasseur, 2002; Nixon, 1997; Nutt, 2006), the role of other caregivers in this had not been highlighted to the same degree as in the current sample. The importance given to this in the current study could reflect a sample bias resulting from the recruitment methodology. The bulk of the caregivers in this sample were recruited from the local Family and Foster Care Association. By implication, the sample already shows a strong proclivity for accessing help from others, in that they have been proactive in accessing and joining a group that is expressly focused on this end. The results in the current study then may reflect the perceptions of a sub-group of caregivers, rather than the population as a whole. It is possible the views of caregivers who are not looking to access further outside support might provide a very different range of support and training perceptions from the current sample. Tarren-Sweeney & Hazell (2006) identified a similar bias in their sample population, notably that *"children placed at an early age in stable, long-term 'adoptive-type' placements"* were underrepresented (Tarren-Sweeney & Hazell, 2006, p. 95). It is possible that the caregivers of such children are also underrepresented in the current study and that they do not tend to seek out help from other caregivers as they do not identify strongly with the fostering community. In the author's experience as a foster parent educational support worker, these types of caregivers can show a tendency to avoid the interference from agencies and associations in what, they consider to be, their private family life, and as such are unlikely to volunteer to participate in activities like the current study. Future research should strive to recruit caregivers who are not members of the local associations, as well as caregivers

who are, to ensure that perceptions are representative of a cross-section of the caregiving population.

Another area that was highlighted in the current study, which differed from the reviewed study (Pacifici, Delany, White, Nelson, & Cummings, 2006), concerned training format preferences identified by the caregivers. The reviewed study by Pacifici, Delany, White, Nelson, & Cummings (2006) indicated that their participants showed high interest and satisfaction in training using multi-media, computer based formats. Participants in the current study showed a varied response to using this method of training. Some of the participants thought it would be of use to be able to access training in their own time, in their own homes through computers or other methods of distance learning. Other caregivers felt this would lead to further isolation, create difficulties in access for caregivers without computers, and the loss of opportunities to exchange ideas in group settings. The networking and exchange of ideas that occurred in group settings was as an important component of training for these caregivers. This discrepancy between findings in the present study and those identified in Pacifici, Delany, White, Nelson, & Cummings (2006) is probably accounted for by different sampling methods. Participants in the latter study were volunteers who had already indicated an interest in enrolling for online courses, meaning that a potential sample bias was present. Hence, participants were already attracted to multi-media, computer based methods of accessing training. In effect satisfaction was high as they were already 'preaching to the converted.' It is also possible that this discrepancy reflects a cultural difference between caregivers on the California Coast and Canterbury. Several of the caregivers in the current study indicated that they did not have computers or access to internet services. It may be that a larger proportion of the caregivers in California do have ready access to these services making computer based training more appropriate for them than the current sample. Again the sample size in the current study is insufficient for population inferences to be made, but further investigation is warranted.

Aside from the high customer satisfaction noted in the research by Pacifici, et al (2006) the issue of the training format preferences of caregivers has not been well covered. However the themes highlighted by the participants in the current study provide ground work for future clarification of training format preferences, should they be replicated across a larger cross-section of caregivers in the New Zealand context. These themes included a preference for training that is offered during school hours, and in the local area. The main topics of interest highlighted were more specific training relating to the etiology and management of the child behaviours the caregivers are actually experiencing on a day to day basis. As noted previously training aimed at 'normal' parenting difficulties does not often work with the type of problems that are encountered in children in out of home care (Pacifici, Delany, White, Nelson, & Cummings, 2006) and caregivers ongoing requests for information on child problem behaviours is a probable reflection of this. Caregivers in the current sample seem to asking for more specific training, focusing on the kinds of clinical problems they are managing daily, rather than the more generic parent training they have received to date. The implications of these findings in the delivery of training to caregivers in the Canterbury area are further explored below.

The present study findings confirm that caregivers encountered a wide range of severe emotional and behavioural difficulties among the children they care for. While many of these difficulties are unusual among the general child population, they are consistent with those reported in the reviewed international literature on children in care (Armsden, Pecora, Payne, & Szatkiewicz, 2000; Keatinge, Tarren-Sweeney, Vimpani, Hazell, & Callan, 2000; Pacifici, Delany, White, Nelson, & Cummings, 2006; Rutter, 2000; Tarren-Sweeney, 2006; Tarren-Sweeney & Hazell, 2006; Tarren-Sweeney, Keatinge, & Hazell, In Preparation). This provides further support for the initial hypothesis, that caregivers in the New Zealand population may be experiencing similar behaviours and difficulties to those generally reported for caregivers of children in care. Further, these results indicate that caregivers in the Canterbury area are

experiencing a range of behaviours among the children they are caring for, that are well outside the normal range of parenting, and which are highly stressful and involve a high burden of care. The correlations between "reported level of preparedness" and factors thought to be indicative of "caregiver experience" (number of years caring, number of children cared for and number of behaviours experienced) assert the difficulty of managing these types of emotional and behavioural difficulties. Allowing for the small sample size, the lack of correlation between the experience factors and how prepared caregivers felt in dealing with behaviours could be viewed as evidence as to how far outside the normal realms of parenting these behaviours fall. Caregiver's perceptions of their ability to deal with these behaviours do not seem to increase as experience increases. (For this assumption to stand up empirically these findings would need to be replicated across a much larger and more representative population of caregivers.)

Further indication of the high burden of care experienced by caregivers is found in the results. The mean Parent and Life Stressors Domain scores fell within the normal range. However, the mean Child Domain sore fell in the high to clinical ranges with some sub-scales being over two standard deviations above the norm. Caregivers are thus reporting that children have high levels of restlessness, distractibility, over-activity, difficulties with concentration and following through instructions, an inability to adapt to change, emotional reactivity, difficulties in calming upset children, high levels of demanding behaviours, whining, and low moods in the children they are caring for, alongside little reinforcement of their parenting role from the children themselves. Elevated levels in all these areas reflect the difficulty of caring for these children reported by caregivers and provides evidence of how demanding the role of foster and whānau caregivers can be. The Acceptability sub-scale scores from the PSI Child Domain were also recorded at two standard deviations above the norm. As noted in the PSI Manual high scores in this area occur *"when the child possesses physical, intellectual, and emotional characteristics that do not match the expectations"* (Abidin, 1990) the caregivers had for them. This means that

not only are the caregivers experiencing a range of difficult behaviours, but that their experiences of caregiving are not what they had expected or hoped them to be. This can contribute to difficulties in caregivers establishing reciprocal bonds with their children, which again impacts on their satisfaction in their role and adds another element of stress to the day to day reality of caring for children in out of home care.

The top priority for support and training reported by participants in the current study was around the behaviours they were experiencing on a daily basis. This is an area that is highlighted in the reviewed literature as one in which caregivers are consistently seeking support (Hudson & Levasseur, 2002; Jones & Morrissette, 1999; McKenzie, 1994; Nixon, 1997; Rutter, 2000; Tarren-Sweeney, Keatinge, & Hazell, In Preparation). These results are thus in line with international findings. This priority reflects the main focus of a perceived need as reported by caregivers in the Canterbury region. Specifically they reported a need for support with understanding how the behaviours originated, how to manage their particular blend of behaviours and training in 'normal' development to enable them to put the current behaviours in context. As already mentioned earlier, at times perceptions of need may not reflect an actual need. The results from the Modified ACC/CBCL and the PSI however, provide supporting evidence that this reflects an actual need, given the range and difficulty of the behaviours caregivers are experiencing. The evidence in support of an actual, as well as perceived need, lends further weight to caregivers' requests for support and training in these areas and highlights the importance of addressing this issue with social service providers. It can be assumed that currently some support and training of relevance has been provided to caregivers in these areas. Support for this assumption can be found by looking at the mean level of preparedness reported by caregivers in dealing with the behaviours and the impact of the number of training modules completed on this. Caregivers reported a mean level of preparedness in dealing with behaviours that was 1.35. This indicates that caregivers are feeling somewhat, though not completely,

prepared to deal with the behaviours they encounter. The correlation between "number of national training modules attended" and the "reported level of preparedness" was meaningful but not statistically significant. Should this finding be replicated across a larger sample size would suggest that the training modules currently being offered by CYFs are have some influence on caregivers feelings of perceived adequacy with the day to day behaviours they are encountering. This is supported by comments from the interviews that the modules were generally considered to provide a good range of basic information. It was also indicated that caregivers would like to see this information extended and tailored to the New Zealand care context.

As identified in the literature five basic categories of support have been identified as necessary for caregivers to maintain their role. They included *"compensation, tangible support, emotional support, relief and recognition"* (Hudson & Levasseur, 2002, p. 857). An analysis of the support provision in each of these areas from the current results indicates some areas in which caregivers report few issues, and others that are of greater concern. The area of compensation, for example, was not mentioned with any frequency by the participants in this study and does not appear to be an area of overwhelming concern. The main area of focus was around the insufficiency of the funding for childcare for caregivers attending training. Caregivers did not refer to the adequacy of their board payments or other compensation they receive. This could be because concerns about financial support are outweighed by other concerns, or because they do not have financial concerns. The lack of financial concerns in this group contrasts with findings from other studies (Hudson & Levasseur, 2002; Nixon, 1997) and requires verification across a wider population in the New Zealand context before assumptions can be made. The themes and issues identified in the current sample, in the areas of tangible support, emotional support, relief and recognition, were all very consistent with those found in the reviewed literature (Hudson & Levasseur, 2002; Jones & Morrissette, 1999; McKenzie, 1994; Nixon, 1997; Nutt, 2006) and have already been well covered.

Limitations of the Current Study

Many of the limitations in this study were foreseen and were due to the necessarily small scale of a dissertation and the exploratory nature of the study. These limitations include the small sample size and the participant response bias due to a sampling bias in the recruitment of participants. The implications of these limitations have been covered above. The modified version of the ACC/CBCL was designed and trialed as part of this study and as with any new tool modifications would be necessary for its future use. The 3-point Likert scale for example was not responsive enough to pick up a comprehensive range of variations in the levels of preparedness. If this tool was to be used again in future studies the author suggests the use of a 5 or 7 point Likert scale. It would be useful in the analysis of the effects of experience on caregiver's feelings of efficacy, to explore reported levels of preparedness when dealing with difficult behaviours that caregivers have experienced versus those they haven't. This information could be obtained by asking caregivers to score preparedness levels for all the behaviours on the Modified ACC/CBCL instead of just those they have experienced. The scale where caregivers indicate the behaviours they have experienced would still be present enabling this comparison to be made.

Another limitation in this study is the use of a domain analysis methodology in the examination of the interviews. While this is a recognised method of analysis (Cohen, Manion, & Morrison, 2003) it is not as comprehensive and detailed as more accepted methods of interview analysis such as discourse analysis (Traynor, 2006). The domain analysis method was chosen due to time and resource constraints, as well as the exploratory nature of this dissertation.

Implications for Current Social Work Practice

The main implications of the current research findings for social work practice revolve around the 'duty of care' that social service providers have, not only for the children in their

custody, but also to the caregivers who provide for these children. CYFs in New Zealand have a responsibility to ensure that the caregivers of children who are under the custody of the Chief Executive are adequately catered for, recompensed and supported in their roles. These caregivers (whether they are whänau carers or foster carers) undertake to fulfill part of the State's responsibility for these children by providing secure and stable living arrangements. The State has a reciprocal responsibility to provide caregivers with the relevant support to enable them to do this. The importance of this is highlighted by Gordon, McKinley, Satterfield & Curtis (2003). They state that:

> *"It is important that the child welfare system demonstrate to caregivers that they are valuable and needed by providing them with appropriate support and services to maintain the children in a safe nurturing home. "After all," one grandmother asked, " what would the agency do without us?"* (Gordon, McKinley, Satterfield, & Curtis, 2003, p. 95)

What this means in practice is that Social Welfare staff need to view caregivers as partners in a joint effort of working towards best possible outcomes for children in care. At present the range of issues perceived by caregivers regarding lack of respect, communication difficulties, the exclusion of caregivers from decision making processes, failure to provided clear information on legal and social services practice, lack of responsiveness and apparent lack of interest by the children's case social workers tend to indicate that caregivers feel they are viewed by social welfare staff as inconveniences to be managed at best, and at worst, adversaries rather than allies. An attitude that relegates caregivers to being considered part of the problem rather than part of the solution is fundamentally at odds with the underlying assumptions of placing children in home based care alternatives. These assumptions, as mentioned in the introduction, are based on the idea that family life is best for children, and that experiences of warm and responsive parenting, provided in alternative families, will help alleviate the potential outcomes

of early adverse family experiences. The focus of the CYFs department should logically be on providing the necessary support and training to caregivers who undertake this role. Given how far outside the range of normal parenting experiences the behaviours foster carers encounter are, it is extremely unlikely that any great number of them will arrive on CYFs books with the full range of requisite skills necessary for the task. In light of this CYFs needs to undertake to provide caregivers with the range of support and training they need to fulfill their role. As noted this requires a fundamental shift in attitude in Children's Case Social Workers and in CYFs practice to firstly acknowledge that they have a 'duty of care' to caregivers, as well as children, and to treat caregivers as equal partners, who have a different, but just as important role in the care of children as the social workers themselves.

In practice this means that CYFs need to develop systems and policies that address the support issues raised by caregivers. One of these issues includes the need for a 'safe' and non-judgmental place to talk about the day to day stresses of caregiving that provides confidentiality for both the caregiver and the children in their care. The participants had two suggestions as to how this could be managed. The first was through the provision of supervision for foster caregivers or counselling for whänau caregivers on a bimonthly basis. The other suggestion put forward by participants was the development of a *"buddy system"* where experienced caregivers are paired up with new caregivers to provide support (a peer supervision system in effect). For this to work effectively and ensure that appropriate peers were chosen as supervisors, it would seem to be necessary that some training and selection procedures were used. It seems that within current New Zealand social welfare structure the inclusion of Caregiver Liaison Social Workers goes some way to addressing this issue given the positive comments from the participants about the support they receive from this group. This should be considered a strength within the department. A third option could be to reinforce and enhance the services provided by Caregiver Liaison Social Workers. Given the small sample size and the restriction of participants to one

local region, further research will need to evaluate whether the high regard for this group of social workers is a regional occurrence, or a nationwide strength within the system.

Themes reported by participants in the present study and elsewhere in the literature such as, “lack of communication,” “lack of respect,” “failure to respond to requests and phone calls,” “failure to follow through with planning decisions” and “follow up referrals” have all been considered as indicators of the lack of regard for the position that caregivers hold within the social welfare system (Brown & Bednar, 2006; Gordon, McKinley, Satterfield, & Curtis, 2003; Hudson & Levasseur, 2002; Nixon, 1997; Nutt, 2006). These factors could also be considered indicators of a system that is under stress and that social workers themselves are not being adequately equipped to meet the needs of all the groups they are contracted to cater for. Support for this view is evident in some responses of participants during the interviews. These included comments about high staff turn over, high social worker caseloads, instances of extended sick leave among social workers and a range of general comments, that indicate the participants in this study at least, are feeling that the system itself is in a state of crisis. *“The whole system’s f@#*ed. Social workers are leaving all the time, we’ve had a guts full. It’s all gonna crash and the papers will love it.”* This highlights a question about ‘duty of care’ that is not well considered in the literature to date. Does the State have a ‘duty of care’ that extends beyond the children and their caregivers to also include the social workers employed to execute the responsibility of the State for the children in its Custody? This issue goes beyond the scope of this paper but is worthy of note, as it has implications for the support and training issues identified by the caregivers in this study. The picture painted about the competency of the children’s social workers looks bleak if it is not considered in the context of the system as a whole. Some of the issues raised can be addressed by a change of attitude in social workers. The provision of relevant training, aimed specifically at addressing the issues of communication, inclusion and respect, that caregivers are voicing, would potentially support this change of attitude. However it seems that the problems

are equally embedded in the social welfare system itself and the provision of funding and restructuring at a governmental level need to be considered rather than just focusing on the ground level staff.

Implications for Future Caregiver Training

Should the findings from this study be replicated across a lager sample, and across a diversity of regions within New Zealand, there are a number of very practical implications for the provision of training to foster and whänau caregivers. These implications cover the format and timing of the training to be offered and the range of topics that caregivers would consider useful.

Participants in the current study indicated that, at present, training is offered during the day and beyond the normal school hours (e.g. finishing at 5pm.) or over weekends. This raises a number of difficulties for caregivers wishing to attend training, the biggest of which is accessing and funding childcare. The funds allocated by CYFs for childcare to enable caregivers to attend training modules are perceived as inadequate to cover the costs. This sends a negative message to caregivers about the importance of attending training. By providing adequate funding for childcare to caregivers undertaking training, a more positive message would be sent about the importance that CYFs places on the value of training caregivers. The message is not only that the training is important for caregivers, but also that the caregivers themselves are important and worthy of training. Of course running training modules during school hours (e.g. 9.30am to 2.30pm) would minimize this issue for a number of caregivers.

This is assuming that a group training format will continued to be used. The findings of the current study seem to indicate that there are a number of caregivers who will continue to prefer this method of training delivery. There are also indications however, that there is a group of caregivers who would find training more appealing and accessible if it were offered using distance learning methods that they could access at home. This is an area where further research

needs to be conducted. This research should consider exploring the number of caregivers who would find distance methods of training preferable; the kind of support mechanisms that would need to be in place to run it successfully (e.g. discussion boards, individual feedback); and the specific modes of delivery the majority of caregivers would find most useful (e.g. internet, CDRom, video or booklets via mail).

The three areas that participants indicated were their top priority for accessing training and support provide a good baseline for the development of future training topics. These areas included, understanding and managing children's behaviours; managing birth family contact; and revision of the legal issues and social services systems, particularly emphasizing permanency, allegations and guardianship and the impact of the Care of Children's Act 2004. As already mentioned the induction training and national training modules are recognized by this group as providing good, basic introductory information. What the participants now seem to be identifying as a training need is information that looks more at the specific, severe and unusual behaviours that children in care present with that are not adequately managed by the usual parenting methods. The involvement of caregivers with birth families also seems to be increasing, and this is an issue that is particularly relevant to whänau caregivers. The specifics that participants have identified as needing to be addressed in this area included managing the children's behaviour after contact; managing their own feelings about birth parents; appropriately supporting children to maintain their family identity; explaining to children why they are in care and answering other questions that children ask relating to their birth families. Topics covering the final priority identified by the participants included understanding allegation procedures and caregiver rights throughout the process; the financial and decision making implications of taking on additional guardianship or permanency; and the specific changes to permanency that are a result of the new parenting orders under the Care of Children Act 2004. Again a larger scale study is needed to assess the replication of these themes across a more representative sample of caregivers. Should

replication of these themes be obtained however, they would provide a comprehensive basis for the development of a training package that is specifically relevant to caregivers in the Canterbury and possibly New Zealand context.

Another issue with training that was touched on in the responses by participants was the question of whether or not it should be compulsory. There are a number of considerations that need to be taken into account when evaluating this, particularly in regards to whänau caregivers. Two separate issues stand out in this area. The first is whether induction training should be compulsory for all caregivers including whänau caregivers. The second is whether there should be compulsory ongoing training for all caregivers. Addressing the first issue, it is interesting to note that the participants who voiced an opinion that the induction training should be compulsory for whänau, as well as foster carers, were all caregivers who had experience in both whänau and foster care. The sole participant who was involved in whänau care only however, did not see that the induction training was relevant to whänau caregivers. Given the under-representation of whänau caregivers in the current sample this is an area that warrants further investigation. It may be that whänau caregivers would benefit from an induction training package that is tailored to meet their particular needs (Gordon, McKinley, Satterfield, & Curtis, 2003). The content of this package may well cover a similar range of material as the current induction course, but would need to consider covering issues that are unique to whänau caregivers, such as dealing with extended family members, particularly the children's birth parents (Gordon, McKinley, Satterfield, & Curtis, 2003). While this training would need to cover information that is common to all kinship carers, consideration should also be given to the development of a training package that is relevant to Maori whänau caregivers. Given the prevalence of Maori children in care, the emphasis on whänau placements (CYFs, 2006) and the unique aspects of caring for children in the extended hapu or iwi context, it is important training is developed for whänau caregivers that addresses their specific needs.. The second issue was that of making some level of ongoing

training compulsory for all foster caregivers. This is an area particularly fraught with a number of complex issues that are again outside the scope of this study. However, if this was to be contemplated the issues of support, timing, delivery mode and content identified in this study would need to be clarified and addressed. Caregivers cannot reasonably be expected to attend training on a regular basis if it is going to incur considerable personal cost. This means that childcare would need to adequately funded, material resources supplied, training be made available in the local area or from home and training that addressed caregivers needs would have to be offered before CYFs could consider making training a compulsory part of the foster caregivers role. At this stage if training was made compulsory the cost this would impose on caregivers would likely have an impact on the number of people willing to take on this role and this would be untenable given the rising numbers of children in care (CYFs, 2006).

Recommendations for Further Study

Areas for further research have been highlighted as relevant throughout the discussion. The primary recommendation is that a replication of the current study be undertaken, using more rigorous methodology in the analysis of interviews, and a larger sample size that includes caregivers from a range of sub-populations. The present study was a useful pilot exercise that provides a basis for the refinements and extension that would be desirable in this more comprehensive study. Other areas for further research that have been mentioned include the relevance of current training packages for whänau caregivers, as well as the training needs of non-Maori kinship caregivers. This research would need to pay particular attention to the cultural relevance of training to Maori whänau. A more comprehensive exploration of the preferred method of delivery for training in the New Zealand context would also be advisable. The value of this research to designers and providers of training should be evident. Training that is delivered in a manner that is appealing to the end users is more likely to be attended especially where the

topics are considered of relevance. Resources for the support and training of caregivers are tight and this emphasizes the importance of researching and evaluating what it is that caregivers are wanting and the most appropriate means of delivery. The areas of further research identified throughout this paper, if undertaken, will provide an excellent basis for decisions about efficient use of these scant funds.

Conclusion

The results of this study provide preliminary support for the hypotheses that caregivers in the Canterbury region of New Zealand are experiencing a similar range of support and training issues as those reported in the reviewed research. Participants report experiencing a range of severe and unusual behavioural, education and emotional problems in their children that are reflective of a clinical population. These difficulties occur in a social welfare context that they perceive as largely lacking in adequate support services. Caregiver's noted a perceived lack of communication and respect from children's social workers; difficulties dealing with birth families; a need for adequate respite services; and access to a safe and confidential people to communicate the many emotional conflicts inherent in their role. Training is reportedly hard to access, covering only basic information. Caregivers are struggling to navigate complex legal and systemic issues and have to continually fight to access diminishing specialist resources. All these factors equate to high levels of stress and a high burden of care among foster and whänau caregivers. Given the critical role that caregivers play in the social welfare system, CYFs will need to take careful note of the support and training needs that caregivers are reporting and make adequate provision to address them. The rising numbers of children being placed in out-of-home care in New Zealand and the potential implications of a continued lack of support on retaining caregiver numbers makes the support and training of foster and whänau caregivers a priority issue for the decision makers in social welfare policy and practice. To end on an encouraging

note, the positive perception of Caregiver Liaison Social Workers is an area of relative strength in the current sample. If this is replicated across regions, this is an existing group of social workers that could be developed to further enhance caregivers' perceptions of the support provided by CYFs.

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APPENDIX 1

INFORMATION LETTER & CONSENT FORM

Caregiver Information Sheet

University of Canterbury
School of Education

Name of Project: Foster/Whänau Caregiver Support Needs Assessment
Name or Researcher: Lyn Murray

Dear

Hi. My name is Lyn. I'm currently studying at the University of Canterbury doing a Master of Education Degree in Child and Family Psychology. As part of this programme I need to complete a research study and I would like to invite you to take part in this. This letter provides an overview of the study and what would be expected from you if you choose to take part.

While a number of you will recognise me from my former employment with Linmark Educational Services, I wish to make it clear that this study is being conducted independently from this service or any other service involved with foster/whänau care. It is being undertaken solely as part of my University requirements.

ABOUT THE PROJECT

The aim of this project is to talk to foster, kinship and whänau caregivers who have provided foster or whänau care for children aged from birth to 10yrs. I am particularly interested in discussing what current or past support you have found useful in your role as a caregiver and any areas where you have felt further support or training would have been helpful. I would also like to talk to you about the range of behaviours that you have encountered from children in your care.

WHAT YOUR INVOLVEMENT WOULD BE?

Your participation in this study will involve an initial interview and a follow up interview, which can either be carried out in your home or some other venue that is convenient to you. Your total time commitment will be approximately 3 hours spread over a two to three week period.

- The initial interview will take around 1 – 1 ½ hours and with your permission the interview will be taped. During the interview we will discuss your background and experiences in foster/whänau caregiving and any previous training that you have undertaken as a foster/whänau caregiver and whether it has helped you. We will also discuss your current support systems and any areas for further support that you would appreciate in your role of providing day to day care for your foster children. I would also be interested in hearing your views on how you think this support or training could be delivered in a way that would make it readily accessible to you.

- Prior to this interview I will also ask you to complete a couple of questionnaires. The purpose of these questionnaires is to give me an idea of some of the child behaviours you are currently or have ever experienced. They will also help me to gain a picture of how you are

currently feeling in your caregiving role. These questionnaires do not require you to write down a lot of information and mostly take the form of circling whether or not you think a statement applies to you.

- During the follow up interview (1/2 - 1 hour) we'll go over any issues from the initial interview that you would like to revisit after having time to reflect. I will also feedback the results of the questionnaires with you, to ensure that you have the opportunity to ask any questions you may have in regards to these.

WHAT HAPPENS TO THE INFORMATION YOU GIVE?

The information that you give me will be kept confidential and no identifying information will be included in the final written report. The information in the report will reflect trends or ranges of answers given by a number of caregivers rather than individual answers. Where a direct quote is used it will be used to illustrate a theme and the individual will not be referenced directly. All tapes and questionnaires will be coded with numbers rather than by name and will be kept in a locked cabinet. Any tapes from interviews will be wiped on completion of the study.

While I am grateful for the support provided by Linmark Educational Services, it is important that you know that neither Linmark, nor CYFs, will have access to any confidential or identifying information that you provide for this study. They will, if they request, have access to the final report document to help support their provision of services to foster/whänau caregivers, but again I emphasize that this will not contain identifying information about specific foster/whänau caregivers.

It is also important that you know you have the right, at any stage during this study, to request that your participation ends and all information you have provided be destroyed.

If you have any further questions or concerns about your involvement in this study at any stage please feel free to contact me on 021 0333 291.

This study is carried out under the supervision of Dr. Karyn France and Dr Michael Tarren-Sweeney who can be contacted through the University of Canterbury. They will be pleased to discuss any concerns or questions you may have about participation in the project.

The study has been reviewed and approved by the University of Canterbury Human Ethics Committee.

Thank-you for taking the time to read through this information sheet. If you are willing to be a part of this study please sign the attached consent form and I will collect it from you at our first interview.

Lyn Murray
Postgraduate Student
Child and Family Psychology
School of Education
University of Canterbury.

CONSENT FORM

Name of Project: Foster/Whänau Caregiver Support Needs Assessment

I have read and understood the Caregiver Information Sheet provided describing to the above named project. On this basis I agree to participate in this study.

I consent to the results being written up and I understand that this report will be written in a way that ensures that no personally identifying material will be included.

I understand that my anonymity and confidentiality will be preserved at all stages of this study.

I understand that withdrawal of consent for participation may be undertaken at any time, including the withdrawal of any information I have provided.

Signature: _____

Date: _____

Contact Name: _____

Phone Number: _____

My Phone Contact Details:
Ph. 021 0333 291
Please feel free to contact me should you need any more information at any stage of this study.

NB. If you do not wish to provide consent, do not sign.

PSYCHOMETRIC INSTRUCTION LETTER

Dear ……

Please find enclosed a copy of the questionnaires that I mentioned in our recent phone conversation. It would be very helpful if you could complete this questionnaire and have it ready for me to pick up when we meet to discuss your support and training needs as a caregiver. Each questionnaire has instructions regarding how to fill it in. Please read these carefully before completing the questionnaire. As I am hoping to gain accurate information about your views, it is very important that you complete these forms independently, without consultation with others on the answers. These questionnaires contain questions that could be upsetting for children so please ensure they are kept in a safe place where children cannot access them. Also please do not consult any child when answering the enclosed questionnaires.

I'll look forward to seeing you for at ……. on …… at 10am

If you have any questions regarding this questionnaire, or need to change our appointment time, please feel free to phone at any time. Ph 03 3838 657

Thanks again for your willingness to participate in this study.

Yours Sincerely

Lyn Murray
Child and Family Psychology Student
University of Canterbury.

APPENDIX 2.

PSYCHOMETRIC FORMS

Caregiver Details Questionnaire

D.O.B _____ **Ethnicity** _____

Gender Male Female

Do you have any biological children? Please provide age and gender.

_____

_____

What was your last year of competed schooling? (e.g. 6th Form or Tertiary etc.) _____

_____

What is your highest academic qualification? _____

_____

Does another adult (e.g. your partner) live in your home and assist in caring for your child/ren? **Yes ☐** **No ☐** **(tick correct answer)**

What is your occupation? _____

What is your partner's occupation (where applicable)? _____

Circle which applies

Whänau/Kinship Carer (I.e. related to the child) **Foster Carer**

If you are a Whänau /Kinship Carer what is your relationship with the children in your care?

_____

How many years have you been a foster/whänau caregiver?

Till now, about how many children (including any current children) have been placed in your care?

Which of the below age groups of children have you had in your care (including current and previous children)? Tick any that apply.

☐ 0-2years ☐ 3-5years ☐ 6-10years ☐ 11years or older

Have you attended a 'foster parent' training course?

If "yes" did you attend this course before or after a child was placed in your care?

Before ☐ After ☐

What kind of care have you involved in providing? (Tick any that apply)

Respite Care ☐ Temporary care ☐ Permanent care ☐

Which agencies are you involved with providing foster or respite care for? (e.g. CYFs, Open Home Foundation, Idea etc)

Modified Assessment Checklist for Children/ Child Behaviour Checklist

Here are some statements that describe children's behaviour and feelings.

For each statement, please indicate whether you have **ever** experienced the behaviour with **any child** you have cared for, up to the age of 10 years.

For those behaviours that you have experienced please indicate how well prepared and confident you felt to deal with the behaviour.

- Circle **0** if you felt completely unprepared and lacking in confidence when dealing with the behaviour.
- Circle **1** if you felt somewhat prepared and moderately confident in dealing with the behaviour.
- Circle **2** if you felt well prepared and confident in dealing with the behaviour.

Please do not check your answers with any child, as this may cause distress or embarrassment.

Tick if you have ever experienced this behaviour				
□	1. Adjusts slowly to change	0	1	2
□	2. Attention-seeking behaviour	0	1	2
□	3. Avoids eye contact	0	1	2
□	4. Can't concentrate, short attention span	0	1	2
□	5. Changes friends quickly	0	1	2
□	6. Clingy or Craves affection	0	1	2
□	7. Distrusts adults	0	1	2
□	8. Distrusts friends	0	1	2
□	9. Does not cry	0	1	2
□	10. Does not share with friends	0	1	2
□	11. Does not show affection	0	1	2
□	12. Easily influenced by others	0	1	2
□	13. Inappropriate eating (e.g. too much or too little, eats things that aren't food, or from garbage, hides/stores food)	0	1	2
□	14. Fearful of men in general	0	1	2

□	15. Fearful or nervous at bedtime	0	1	2
□	16. Finds it hard to make decisions	0	1	2
□	17. Fears rejection	0	1	2
□	18. Gives up too easily	0	1	2
□	19. Has an imaginary friend	0	1	2
□	20. Has nightmares	0	1	2
□	21. Hides feelings	0	1	2
□	22. Hugs men, other than relative or male carer	0	1	2
□	23. Is fearful of being harmed	0	1	2
□	24. Lacks guilt or empathy	0	1	2
□	25. Laughs when injured or hurt	0	1	2
□	26. Manipulates or 'uses' friends	0	1	2
□	27. Play includes violent or frightening themes	0	1	2
□	28. Precocious (talks or behaves like an adult)	0	1	2
□	29. Prefers to be with adults, rather than children	0	1	2
□	30. Refuses to talk	0	1	2
□	31. Relates to strangers 'as if they were family'	0	1	2
□	32. Resists being comforted when hurt	0	1	2
□	33. Secretive	0	1	2
□	34. Startles easily	0	1	2
□	35. Suspicious	0	1	2
□	36. Thinks he is someone or something else	0	1	2
□	37. Has low self esteem, thinks others are better than they are	0	1	2
□	38. Too compliant (over-conforms)	0	1	2
□	39. Too dramatic (false emotions)	0	1	2
□	40. Too independent	0	1	2
□	41. Treats you as though you were the child, and they are the parent	0	1	2
□	42. Tries too hard to please	0	1	2
□	43. Uncaring (shows little concern for others)	0	1	2
□	44. Very forgetful	0	1	2
□	45. Wants to be treated like a baby, or a toddler	0	1	2
□	46. Wary or vigilant	0	1	2
□	47. Won't attempt new activities	0	1	2
□	48. Asks to be physically punished	0	1	2
□	49. Attempts suicide	0	1	2
□	50. Causes injury to themselves	0	1	2

□	51. Causes themselves to vomit	0	1	2
□	52. Cuts or pulls out their hair	0	1	2
□	53. Causes damage to property	0	1	2
□	54. Describes or imitates sexual behaviour	0	1	2
□	55. Distressed by traumatic memories	0	1	2
□	56. Does not show pain if physically hurt	0	1	2
□	57. 'Flirts' with strangers	0	1	2
□	58. Forces or pressures children into sexual acts	0	1	2
□	59. Hits head, head-banging	0	1	2
□	60. Kisses with open mouth	0	1	2
□	61. Masturbates at home in view of others	0	1	2
□	62. Rocks back and forth	0	1	2
□	63. Seems to be in a trance	0	1	2
□	64. Engages in sexual behaviour not appropriate for their age	0	1	2
□	65. Shows sex parts to children (other than siblings)	0	1	2
□	66. Talks about suicide	0	1	2
□	67. Threatens to injure or kill themselves	0	1	2
□	68. Throws themselves against walls, onto floors etc	0	1	2
□	69. Unhealthy drinking (e.g. from a discarded drink bottle, from toilet bowl)	0	1	2
□	70. Won't say when physically hurt	0	1	2
□	71. Acts too young for their age	0	1	2
□	72. Can't stand having things out of place	0	1	2
□	73. Can't sit still, restless or hyperactive	0	1	2
□	74. Can't stand waiting, wants everything now	0	1	2
□	75. Constantly seeks help	0	1	2
□	76. Cruel to animals	0	1	2
□	77. Disturbed by any changes in routine	0	1	2
□	78. Does not want to sleep alone	0	1	2
□	79. Doesn't answer when people talk to him/her	0	1	2
□	80. Doesn't know how to have fun; acts like a little adult	0	1	2
□	81. Doesn't want to gout of home	0	1	2
□	82. Gets hurt a lot, accident prone	0	1	2
□	83. Gets into many fights	0	1	2
□	84. Looks unhappy without good reason	0	1	2
□	85. Nervous, high-strung, or tense	0	1	2
□	86. Shows panic for no good reason	0	1	2

☐	87. Poorly coordinated or clumsy	0	1	2
☐	88. Screams a lot	0	1	2
☐	89. Seems unresponsive to affection	0	1	2
☐	90. Smears of plays with bowel movements	0	1	2
☐	91. Speech problems	0	1	2
☐	92. Shows too little fear of getting hurt	0	1	2
☐	93. Stares into space or seems preoccupied	0	1	2
☐	94. Sudden changes in mood or feelings e.g. between sadness and excitement	0	1	2
☐	95. Too concerned with neatness of cleanliness	0	1	2
☐	96. Too fearful or anxious	0	1	2
☐	97. Wanders away	0	1	2
☐	98. Withdrawn, doesn't get involved with others	0	1	2
☐	99. There is very little he/she enjoys	0	1	2
☐	100. School aged child with bowel movements outside toilet	0	1	2
☐	101. Confused or seems to be in a fog	0	1	2
☐	102. Cruelty, bullying or meanness to others	0	1	2
☐	103. Doesn't get along with other kids	0	1	2
☐	104. Fears certain animals, situations, or places	0	1	2
☐	105. Hangs around with others who get in trouble	0	1	2
☐	106. Hears sounds of voices that aren't there	0	1	2
☐	107. Physically attacks people	0	1	2
☐	108. Prefers being with older kids	0	1	2
☐	109. Prefers being with younger kids	0	1	2
☐	110. Refuses to talk	0	1	2
☐	111. Runs away from home	0	1	2
☐	112. Sets fires	0	1	2
☐	113. Steals inside or outside the home	0	1	2
☐	114. School aged child who wets self during the day	0	1	2

Modified ACC & CBCL Score Sheet

Caregiver -

ACC - Subscales

Sexual Behaviour		
Items	Behaviour	Preparedness
54		
57		
58		
60		
64		
65		
Total	0	0
Average Level of Preparedness		#DIV/0!

Insecure		
Items	Behaviour	Preparedness
17		
21		
30		
34		
38		
42		
Total	0	0
Average Level of Preparedness		#DIV/0!

Psuedomature		
Items	Behaviour	Preparedness
28		
29		
39		
40		
41		
Total	0	0
Average Level of Preparedness		#DIV/0!

Non- Reciprocal		
3		
10		
11		
24		
26		
27		
32		
33		
35		
43		
Total	0	0
Average Level of Preparedness		#DIV/0!

Anxious/Distrustful		
7		
8		
14		
15		
20		
23		
45		
46		
55		
Total	0	0
Average Level of Preparedness		#DIV/0!

Indiscriminate		
2		
5		
6		
12		
22		
31		
Total	0	0
Average Level of Preparedness		#DIV/0!

Food Maintenance		
13		
69		
Total	0	0
Average Level of Preparedness		#DIV/0!

Abnormal Pain Response		
9		
25		
56		
70		
Total	0	0
Average Level of Preparedness		#DIV/0!

Self Injury		
48		
50		
51		
52		
59		
62		
68		
69		
Total	0	0
Average Level of Preparedness		#DIV/0!

Suicide Discourse		
49		
66		
67		
Total	0	0

Other - Inattentive		
4		
44		
Total	0	0
Average Level of		

Low Confidence		
1		
16		
18		
47		

Average Level of Preparedness	
	#DIV/0!

Negative Self Image		
37		
Average Level of Preparedness		0.00

Other- Sexual Items		
61		
Average Level of Preparedness		0.00

Preparedness	#DIV/0!

Other - Dissociative		
19		
36		
63		
Total	0	0
Average Level of Preparedness		#DIV/0!

Total	0	0
Average Level of Preparedness		#DIV/0!

Behaviour Scoring
Experienced = 1
Not Experienced = 0

Preparedness Scoring
Well Prepared = 2
Somewhat Prepared = 1
Not Prepared = 0

CBCL - Subscales

Internalising Sub Scales

Emotionally Reactive		
Items	Checked	Preparedness
77		
86		
94		
Total	0	0
Average Level of Preparedness		#DIV/0!

Anxious/Depressed		
Items	Checked	Preparedness
84		
96		
104		
Total	0	0
Average Level of Preparedness		#DIV/0!

Somatic Complaints		
Items	Checked	Preparedness
72		
85		
95		
20		
Total	0	0
Average Level of Preparedness		#DIV/0!

Withdrawn/Depressed		
71		
79		
89		
98		
99		
110		
Total	0	0
Average Level of Preparedness		#DIV/0!

Externalising Sub Scales

Attention Problems		
Items	Checked	Preparedness
73		
87		
97		
4		
101		

Aggressive Behaviour		
Items	Checked	Preparedness
53		
74		
83		
88		
102		

Rule Breaking Behaviour		
Items	Checked	Preparedness
105		
108		
111		
112		
113		

Total	0	0
Average Level of Preparedness		#DIV/0!

107		
Total	0	0
Average Level of Preparedness		#DIV/0!

Total	0	0
Average Level of Preparedness		#DIV/0!

Other Problem Scales

Sleep Problems

Items	Checked	Preparedness
78		
Average Level of Preparedness		0.00

Social Problems

Items	Checked	Preparedness
103		
109		
Total	0	0
Average Level of Preparedness		#DIV/0!

Thought Problems

Items	Checked	Preparedness
106		
Average Level of Preparedness		0.00

Other Problems

75		
76		
80		
81		
82		
90		
91		
92		
93		
100		
114		
Total	0	0
Average Level of Preparedness		#DIV/0!

CBCL - Subscales

DSM IV Orientated Scales

Affective Problems

Items	Checked	Preparedness
84		
99		
Total	0	0
Average Level of Preparedness		#DIV/0!

Attention Deficit/ Hyperactivity Problems

4		
73		

Anxiety Problems

Items	Checked	Preparedness
78		
81		
85		
86		
96		
104		
20		
Total	0	0
Average Level of Preparedness		#DIV/0!

Pervasive Developmental Problems

Items	Checked	Preparedness
74		
77		
79		
89		
91		
98		
Total	0	0
Average Level of Preparedness		#DIV/0!

74		
Total	0	0
Average Level of Preparedness		#DIV/0!

Conduct Problems		
53		
83		
102		
105		
107		
111		
112		
113		
Total	0	0
Average Level of Preparedness		#DIV/0!

Total Composite Scores

Total Behaviours Experienced	Total Level of Preparedness	Average Level of Preparedness

("Care of Children Act", 2004)